

**Care matters: spiritual care by nurses from
feminist perspectives**

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Abstract

The importance of spiritual care by nurses for health and recovery has become increasingly topical in the last decade. However, there is little research into why nurses should give spiritual care. Whilst bodily caring has always been associated with nurses and nursing, spiritual care has been seen as the concern of religious ministers. The steady decline of people belonging to conventional religions in secular British society is paralleled by an upsurge of interest in spiritualities. But why nurses should give spiritual care is unclear. This qualitative, interdisciplinary study aims to explore why nurses are asked to give spiritual care to patients by considering whether there is something amiss with nursing care that would be remedied by the addition of spiritual care. To investigate this, spiritualities and bodily caring are considered in tension with each other. By using feminist standpoint epistemological approaches I propose to: a) allow the everyday experiences of nurses in giving nursing care to be expressed; b) demonstrate that themes of nursing care as comforting, compassionate caring challenge claims that the addition of spiritual care is necessary; c) show that nurses conform to the perverse body/spirit dualisms of dominant patriarchal institutions and cultural norms in describing bodily nursing care as spiritual and d) present living models of nurses and nursing care as meaningful materialist world views.

Material for the study was obtained in semi-structured, one-to-one conversational interviews with eighteen experienced practising nurses. Stories of nursing care were interpreted and analysed within nursing theories of spiritual care as either imperative or integral to nursing care. Body/spirit critiques in feminist informed theologies provided a further theoretical framework for analysis.

The thesis describes the everyday distress that nurses experience. The feminist design created a vehicle for fresh constructs of care by nurses not previously identified in studies of spiritual care by nurses. The findings provide an evidence base for practising nurses to validate their own skills; for managers and policy makers in planning support for nurses to give nursing care, as well as for chaplains and others to listen and respond to care matters.

Introduction

*We have intrinsic aims such as the relief of physical and psychological suffering
but attention to social and spiritual needs is an extrinsic aim.*
(Doyle 1996: viii)

This study is a qualitative enquiry into why nurses are asked to give spiritual care to patients. In the past decade a growing and increasingly significant literature, as well as conferences and professional guidelines, have all emphasised the need for spiritual care by nurses. Compared to cultural/religious practices and how these affect nursing care, spiritual care seems nebulous. In an increasingly secular culture, 'spiritual' is said to be a meaningless concept (McSherry (2002). Human values of justice, concern for others and the world; poetry, music, theatre and dance as well as fitness and sport may be 'spiritual' in a secular sense. Yet, paradoxically, in an increasingly secular Britain, with the decline in formal religious belonging, the rise in individualism and market forces, there has been an upsurge in spirituality. Indeed, it has become both a buzz word and a consumer product. An individual can choose from a wide range of processes and products, from Reiki to Roman Catholicism, Cosmic Awakening to Christianity, and Paganism to Presbyterianism, with numerous shades of spiritualities within and between, these traditions. Or the individual can choose to follow none of these practices But, as Bellamy (1998) comments, there is a considerable difference between human values in life, and spiritual relationship to or with a transcendental God.

I wondered if there was a connection between these social trends and the increasing recommendations that nurses should give spiritual care to patients. As well as nursing theories spiritual care, professional guidelines also include spiritual care-giving by nurses. Does such a dimension as 'spiritual' exist, and, even if it does, why is it the nurse's role to give spiritual care? Although there has been some questioning of nurses giving spiritual care, on the whole it is agreed to be a good thing. Robinson (2000), as editor of the *Journal of Advanced Nursing*, wrote that "Like mother love and apple pie, spirituality seems to be a good thing." (p.431) However, she continued

that “integrating spiritual care into nursing raises cogent issues of definition and ethics” (p.431). Doyle (1996) wrote:

It is rarely questioned whether we have as much right to involve ourselves in spiritual issues as we have in psychological and psycho-social suffering; commitment to the ‘total good’ is intrinsic to our roles as carers. (viii)

Many professional guidelines mention spiritual care but do not distinguish it from respect for cultural values and beliefs and practices. Indeed, the terms can be used interchangeably. The Patient’s Charter (1991) recommends staff to “acknowledge their [patients’] spiritual needs and aspirations, privacy, dignity, cultural beliefs and dietary requirements.” (p.5)

Likewise, the Nursing & Midwifery Council (NMC 2004) Code of Professional Conduct includes “culture and religious [...] beliefs” (pp.3-4) as part of protecting and promoting the interests and dignity of patients.

However, The Scottish Executive Guidelines NHS HDL (2002) distinguished between religious and spiritual care. Spiritual care was said to be practised in a one-to-one relationship and was not based in religious faith or practices. The guidelines repeatedly made the point that spiritual care needs were to be addressed by all NHS staff, and not just chaplains and religious community leaders.

The World Health Organisation (WHO 1998) included spiritual aspects as part of their definition of health, whilst The International Society of Nurses in Cancer Care (ISNCC) (1991) suggested that educational programmes should have a core module on spiritual care.

There are, then, questions about what spiritual care is, as well as related ethical and professional questions. How can a nurse be professionally competent to give spiritual care across the kaleidoscope of spiritualities currently on offer? Patients, after all, come to hospital and clinics to have their various medical problems remedied but do they also expect nurses to be competent in giving spiritual care, even supposing there was agreement about what this is? I wondered if there was some problem with nurses or nursing care, and if so, would spiritual care by nurses be the remedy?

The structure of the thesis

Following this brief introduction to the topic, Chapter One describes and discusses the concepts and theories of spirit and caring which are necessary for an investigation of why nurses are asked to give spiritual care to patients. It appears that nurses are asked to give spiritual care to patients because of the belief that life is material and spiritual. Consequently a discussion of traditional and contemporary concepts of spirit, spiritual and related or borderline concepts of soul, mind, psyche and self are discussed. The dominant nursing discourse argues that nurses should give spiritual care to enable patients find meaning, purpose and fulfilment. These concepts of spiritual care are understood as transcendental to bodily life (Waugh/Ross 1992/1997). These claims are examined, together with a less dominant claim that nursing itself is spiritual (Bradshaw 1994). This led me to investigate literature on nursing and caring, as well as studies which examine aspects of the complex debate about patients' experiences of both caring and body/mind-spirit. Since there are gender aspects to nursing, caring and spiritual constructions of cultural/religious¹ practices, I question how these might be interrelated. Literature from feminist informed theologies and spiritualities provided analytical tools for questioning the possible effects of spiritual care which is separated from bodily care.

Taken together with Chapter One, a discussion of knowledge construction and claims to its worthwhileness in research is presented in Chapter Two. Feminist standpoint epistemological approaches to my study derived from Marxist materialist political philosophy are described. Interviews, narrative and reflexive methods and processes of research used during one-to-one interviews with eighteen experienced practising nurses are included.

In Chapters Three, Four and Five, the findings from material gained in the interviews are presented. Specifically, I asked what the nurses thought 'spirit' and 'spiritual care' to be and if they considered that they gave it and if so, how, when and why. I

¹Contemporary use of the term 'religious practice' rather than 'religion' reflects the synonymous nature of religion and culture (Nye, 2000). Therefore, I use 'religious practice' to mean those beliefs, practices and values, hopes and fears, which, in time, become rituals, held to be sacred by whichever community values them.

felt that in the nurses' descriptions of their own experiences of giving nursing care, I would gain an understanding of current everyday nursing. Furthermore, I would be able to see if there was something lacking in nurses themselves, or in current nursing practice, which would be remedied by giving spiritual care. I analysed the conversations around the themes that emerged throughout the study. These were: difficulties with articulating what spirit and spiritual care were; difficulties with finding meaning in the definition of spiritual care as meaning purpose and fulfilment; descriptions of spirit and spiritual care as non-religious, such as energy, inner self and person; difficulties with distinguishing spiritual care from personal nursing care, as well as problems of being a nurse and with nursing within hierarchies of medical and management structures.

Chapter Three presents an account of the nurses' beliefs and experiences of spirit and spiritual care and how they consistently struggled to describe what they thought of as spiritual care in nursing. Their differing views are presented in accordance with the interview conversational topics and emerging themes of caring for the spirit, variously described as 'essence,' self,' 'energy' and sometimes, religiously, as 'spirit' or 'soul'.

Because the generally accepted working definition of spiritual care in the nursing literature was that it was about helping a person find meaning, purpose and fulfilment I asked the nurses specifically if, in their experience, spiritual care was helping patients with meaning, purpose and fulfilment. Defining meaning purpose and fulfilment as spiritual, however, was equally problematic for many nurses. Ethical and professional complexities and competence issues emerged as of central importance. These findings are presented and discussed in Chapter Four.

Chapter Five continues the presentation of the interview materials with an attempt to focus on the nursing aspect. The difficulties of separating spiritual from nursing care became a distinct feature of my study and so the presentation of the findings in discrete themes is therefore unrepresentative of the actual experiences of the nurses and the interviews.

Apart from finding out what nurses' perceptions of spiritual care may be, earlier studies of spiritual care by nurses had paid little attention to the actual experiences of nurses in giving nursing care. An interesting finding in my study was the consistency

with which nurses identified their own unmet inner distress as spiritual: *to care for myself, to reinforce myself spiritually*, as study participant Joan expressed it. The dearth of systematic or formal support for nurses and patients, together with unhelpful attitudes and work practices, compounded their stress-related distress. Directly or indirectly, the roles of gender and power were intertwined in the situations described by the nurses in my study.

The last chapter provides a summary of the study findings and offers a speculative discussion that the current move to add spiritual care to nurses' roles may maintain the status quo of nursing as powerless relative to other disciplines and thus deflect from and destabilise more important issues and concerns.

In the last part of the chapter implications of my study for further research into what spiritual care is are suggested. Enabling nurses to use and develop existing bodily nursing care skills requires effective support strategies for and by nurses. I suggest that grounding these initiatives in concrete care matters is vital to patient care, nurse recruitment and retention. This has important implications for policy makers, practitioners and patients.

CHAPTER ONE

Spirit, body and caring: theories and concepts

In this chapter I discuss the key concepts and theories necessary for an investigation of why nurses are asked to give spiritual care to patients. Although there is other literature on spiritual care by nurses, this mostly argues from the same base as the influential doctoral study by Waugh/Ross (1992/1997), and it is therefore this study on which I concentrate. Ross concluded that spiritual care by nurses was imperative whilst the less dominant study by Bradshaw (1994) argued that nursing was itself spiritual. This therefore raises important questions about nursing care, and specifically why nurses should be asked to give spiritual care. The two differing approaches to spiritual care by nurses presented in these key nursing studies form the framework of my study, so although I discuss the main features of them here, I expand on them throughout the thesis. I consider bodily caring to try to understand what it is about care that may be spiritual in the sense that Bradshaw indicated, or to understand why nurses should give spiritual care as claimed by Ross et al.

In order to understand why nurses should be expected to give spiritual care it is necessary to scrutinise the concepts of spirit and caring. Miers (2002) argued that “The significance of an interpretation of any concept lies in its relationship to a body of theory.”(p.71) whilst Dickoff & James (1968) similarly argued that concepts need to be seen in their disciplinary context before investigating their relevance to nursing. As Henery (2003) observes:

...many nursing writers see their task as a secondary one of conceptual clarification of spirituality or practical implementation of spiritual care.
(p.551)

Therefore, before discussing the studies on spiritual care by nurses, I will briefly consider the theoretical and disciplinary contexts of the concepts of spirit and caring in nursing.

Although I include secular concepts of spirit as self and mind, more attention is given here as throughout my thesis to Christianity since it is said to be the origin of spirituality (King 1997). Furthermore, whether implicitly or explicitly Christian it appears that world-views feature in the dominant discourse on spiritual care by nurses.

Within the disciplinary contexts of feminist-informed theologies and spiritualities, I go on to discuss the arguments that patriarchal constructions of spirit/body dualisms have subjugated women and the body, since this has direct bearing on my research question.

Definitions of spirit and spiritual

Spirit-breath

The concepts ‘spirit’ and ‘spiritual’ are elusive and ambiguous and notoriously difficult to define. The *Oxford English Dictionary* defines ‘spirit’ as “The breath of life which gives life to the organism”.

In the pre-scientific creation myths of the Hebrew Bible/Christian Old Testament (OT), it is God’s breath, *ruah*, which is said to give life to a human body of earthly clay (Gibson 1981). Sometimes ‘breath’ can be *nephesh*. In the later Greek version of the Hebrew Bible/Christian Old Testament (OT) the Septuagint, ‘*ruah*’ is translated as ‘*pneuma*’, meaning literally ‘breath’ or ‘wind.’ English translations subsequently rendered ‘*ruah*’ and ‘*pneuma*’ as ‘breath’ or ‘spirit.’ Other key biblical words for ‘spirit’, such as ‘*shekinah*’, ‘*hokmah*’ or ‘*sophia*’, are also feminine, or neutral, in gender.

The feminine gender of the Hebrew word for breath, *ruah*, later appeared in masculine form when combined with the word for ‘Holy,’ as in Holy Spirit or *ruah ha kodesh*. Use of the word ‘holy’² separates life into unholy and holy, or a realm of material, earthly bodily concerns, such as the sexual body as ‘sinful’, and a realm of spiritual activities as saving from sinfulness. Holiness is religious, specifically

² Although it is used derivatively in English to mean ‘whole’ ‘health’ and ‘wholeness,’ as Barr (1961:112) demonstrated, this has no relation to the use of ‘holy’ in the Bible.

Christian, and has as its root the notion of 'inviolability' or being 'untouchable'³. This not only changed the gender of the concept 'spirit' but separated it from earthly life. (B.D.B. Hebrew Lexicon)

The *Cambridge Dictionary of Philosophy* (CDoP 1995) cites the Greek translation as '*pneuma*' or breath, and the Latin '*anima*' or spirit. Spirit is synonymous with 'soul'. Indeed the dictionary entry for 'spirit' simply states "See *Soul*". It is generally believed to leave the body at death. The soul is said to enable self-consciousness and thereby accounts for a person's identity.

Spiritual

As an adjective of 'spirit,' 'spiritual' is an umbrella term meaning whatever lies beyond the material. Speck (1998) defined it as a search for existential meaning within a life experience, with reference to a power other than the self, which may not necessarily be called 'God' (p.22). Some religions/cultures, however, teach that 'spiritual' means investing this earthly life with value which gives meaning. For instance, 'spiritual' matters are often of this world in most of Judaism. Kushner expressed it as "a guide to investing your life with things that really matter" (p.293) rather than wasting it on the trivial, with the sense that the whole of the way of life is important, including the mundane, thereby possibly 'spiritualising' the normal. Of course, that presupposed the existence of a transcendental God who was nevertheless immanent and met with people on earth, as told in the stories in the Bible.

Spirit /soul

In an analysis of mystery religions and philosophies of ancient Greece and the surrounding areas, Jantzen (1995) made a strong, detailed argument for their influence on the ideas of the spirit or soul within Christianities. She continued that spirit-soul mind was identified with maleness or men, and the body with woman. The ensuing misogyny of such constructions has therefore become a central concern to feminist critiques of spirit/soul and effects on the body, women and society. The

Rothschild (1996) In Isherwood L. & McEwan D. (eds.) (1996) *An A-Z of Feminist Theology*, Sheffield, Sheffield Academic Press, p. 245). Feminist interpretations of this are 'Being,' 'eternal existence' 'One Who is', 'Source of Life, 'You' (p.245).

influence of the Greek philosopher Plato (427-347 BCE) on Christian views of the spirit have been well discussed elsewhere (see, for instance, Louth 1981, McGinn 1991). Whilst it is not the concern of my thesis to investigate this complex area in depth, it is nevertheless important to note it. However, the gendered aspects of spirit and the effects on the body are of specific concern since nurses traditionally care for the body and my research quest is why they should care for the spirit, and in addition what and where spirit is or may be.

The belief in the spirit/soul as superior to, and separable from, the body was evident in the sixth century BCE in the philosophy of Pythagoras for whom the soul was incorruptible but yoked, or entombed, in the corruptible, physical body. The body was thus to be controlled, and particularly denied its pleasures, so that the spirit could gain wisdom, which was related to immortality (Robinson 1968).

Plato described the spirit as the rational part of intelligence which had to be detached as much as possible from bodily senses and concerns since the body was considered a hindrance to true wisdom. Plato portrayed the soul/spirit as divisible into three parts: “reason, a spirited element and the bodily desires”, of which reason was the ruling part, with the spirited part as an “executive auxiliary” controlling bodily desires (Matthews 1972:86).

In the *Phaedo* and the *Republic V* Plato depicted the ‘soul’ as trapped inside the body, weighing it down and preventing it from reaching the heights of the Good and the True. However to Plato this ‘soul’ was the real self; it was only the soul which had access to higher wisdom, both given by God at birth (or conception) and returned to God after death. In the *Phaedo*, where Plato specifically discussed the immortality of the soul, he said in his dialogue with Simmias that after death:

...the soul will be by itself without a body but not before [...]. If we are freed from the follies of the body, it seems likely that we shall join the purified and know for ourselves all that is pure; and this is perhaps the truth. (67a)

Sometimes Plato depicted the struggle for achieving higher wisdom or oneness with the One as being in the spirit, rather than between the spirit and the body (*Phaedrus* 253d-256b). Since Plato, the soul/spirit has been considered to be immaterial and

freed from the physical constraints of the human body, not the least of which was its certain death and dissolution. Since Aristotle (384-122 BCE) however, more sceptical philosophers have maintained that the soul could not live in a disembodied state.

Although in his later work in the *Republic* Plato discussed the equality of men and women, in the *Phaedo* and *Phaedrus* he used masculine words for 'soul'. If women were mentioned at all, it was only in terms of reproduction and mothering. Aristotle and his pupil Plato would have attributed this to the essence of things, namely that women naturally reproduced whilst men created culture, from which women, along with slaves, were excluded (*Republic* V 455de and context). Consequent on this was a hierarchical "...insistence on the soul-spirit or mind rather than the embodied creature or the real person" (Lovibond 2000:16).

Spirit-mind-psyche-self

'Spirit' (or 'soul') can be considered as related concepts to 'mind' since both are said to be entities with immaterial attributes, such as thought, emotions, memory, self-consciousness and personal identity (Schumm 1995: 755).

As the mind is involved in thinking, and thought has not been considered as physical substance, so mind too is believed to be separate from the body. Hence, a dualism of mind/body has been influential in Western science and philosophy (Cottingham 1995:196). This is evident in the famous dictum of the philosopher Descartes (1586-1650): *ergo sum ergo est* ('I think, therefore I am'). Feminist philosopher Tong (1995) commented, however, that people want to know more than [the fact] that they exist and this involves more than thinking, for usually life involves relationships with others. However, it is argued that 'mind' is used in a way that represents it as objective and rational, as it has been developed in Western, scientific psychiatry, where it is said to be synonymous with *psyche*. This is said to misrepresent Freud's German '*Seelenleben*', which means 'soul-life' or 'innermost being' - an 'inexact emotional resonance' (Bettelheim 1985). This 'innermost being' can be generally understood as consciousness, 'me,' 'the person' or subjective 'self'.

Thus there are overlapping meanings between ‘mind’, ‘self’, ‘soul’ and ‘spirit’ and this suggests that ‘psyche’ or ‘mind’⁴ might be the same phenomenon as ‘soul’ or ‘spirit’. If so, then this raises questions about whether the spirit is different from, or integral with, other bodily experiences.

Contemporary or ‘New Age’ Spirit

As mentioned in the introduction to my thesis (p.9), it is argued by scholars in the sociology of religion that despite or even because of secularism, the persistence of the sacred is evidenced in contemporary and secular spiritualities (Davie & Cobb 1998). Indeed, Sutcliffe (2003) argued that:

...in the early twenty first century this diffuse and popularised discourse of spirituality has become fairly comfortably established across the cultural spectrum as a symbolic repudiation of organised religion. (p.223)

Yet, as scholars note, these New Spiritual Movements (NSMs) or New Religious Movements (NRMs)⁵ are effectively

...an emic repackaging of popular and vernacular religion to suit the peculiar conditions of industrial and post-industrial societies.
(Sutcliffe & Bowman 2000:5)

Indic spiritual paths are commonly evident in Western ‘New Age’ practices, in particular Yogas and Buddhist meditations. However, these may be practised more for their physical health-giving properties than as spiritual paths per se, and are separated from the cultural milieu in which they originated, in particular from the dietary and moral aspects.

Although a slippery term, ‘New Age’ covers a wide range of movements and beliefs described by Hedges and Beckford (2000) as follows:

Beliefs and practices are an anticipation of a hoped for state of affairs, which is conditional upon people living their lives in the present as if a New Age had

⁴ I return to discuss these concepts in Chapters Three, Four and Five and at various points in the thesis, in relation to study materials.

⁵ An estimated 500 NRMs exist in Britain (Beckford 1985).

already dawned. This requires faith, or at least a radical suspension of doubt.
(p.170)

As Bruce (2000) commented: “At their most banal these new spiritual movements look for the best in all possible worlds” (p.233). A note in my reflective diary records how a Roman Catholic member of staff was undertaking a pilgrimage to Medjugorje, a village in Bosnia-Herzegovina⁶ where “Our Lady” was believed to have appeared to several people with messages from God. The staff member asked academic and secretarial staff if they wanted her to take something of theirs to leave on the mountain of “Our Lady” so that they could thereby be blessed by her. In a in a Presbyterian or secular culture such as that Scotland, it was surprising that out of fifty or so staff, some forty gave her something personal to take for them.

Within contemporary spiritualities the concept of spirit can be thought of as that which connects with the source, or Source, or principle of life energy. The emphasis is on self-realisation and inner divinity rather than necessarily relating to an external God, however described. Instead, the focus in these spiritualities is on inner wisdom, intuition, and above all, personal experience, over and against institutional religion and/or rational argument or scientific validity for their claims. Some of them are highly individualistic, self-directed and self-centred. Lyon (2000) likened the use of these spiritualities to shopping for a self as if in a “...shopping mall...of religious and quasi-religious elements focused on the self and choice” (p.117). The self is within, often as an inner voice, soul, spirit, or energy, to be located and listened to in finding a balance between body-mind-spirit, particularly in relation to self-healing and stress management. Those seeking such spiritual practices are predominantly women, managers, and professionals and white middle classes. Sutcliffe (2003) stated that

This diffuse and popularised discourse of spirituality... has an almost entirely white, middle-class demography, largely made up of professional, managerial, arts and entrepreneurial occupations. It is also well represented by women, by dint of its reclamation of skills and attributes traditionally consigned to domestic realms and predominately

⁶ For more on this see www.medjugorje.org/overview.html. [Accessed 22/04/04]

gendered as 'feminine', such as emotional empathy, bodily awareness and interpersonal skills. (p.223)

Other contemporary movements however are altruistic and based on community and/or global issues, such as the environment⁷ and war; others overtly return to older practices such as Paganism⁸ (Heelas 1996) or Wicca.⁹ Eco-feminism combines both of these directions; it seeks to break down the barrier between spirit/matter, nature/culture and aims at a more peace-loving, non-hierarchical alternative culture, able to address wider social, personal and ecological matters. Starhawk, a well-known witch and feminist priestess of the Goddess¹⁰ movement, described the complex connections of the self-spirit with the universe:

Each individual self is linked by ties of blood and affection to the coven, which in turn is a part of the larger human community, the culture and society in which it is found, and that culture is a part of the biological/geographical community of Planet earth and the cosmos beyond, the dance of being which we call Goddess.

(Starhawk cited in Spretnak 1982:418)

There is then a tension between the self as a reflexive project and the self in community. Giddens (1991) argued that the tension is made necessary by the erosion of traditional communities such as the family, the church and traditional forms of expertise e.g. medicine and the National Health Service (NHS). There is a tension between inner and outer aspects of authority which Hedges & Beckford (2000) stated as:

The pressing problems of the natural environment, new technologies and biological reproduction and globalisation are taken into consideration in

⁷ David Starkey of the London School of Economics estimates that in Britain, membership of environmental groups is around 5 million compared to 3.7 million church-goers, and argues that ecology has replaced Christianity as the new religion of our age (*Independent* 27 May 1996).

⁸ Paganism stems from *pagus*, Latin for rural or countryside, thus reverence for nature and maintaining human life in harmonious connection with the cycle of the seasons is a strong feature of contemporary Paganism. However magic, mystery, the occult and association with unseen powers can be 'spiritual' or 'other-worldly' (Greenwood in Sutcliffe & Bowman 2000).

⁹ Wicca is discussed later in this Chapter.

¹⁰ I discuss aspects of Goddess movements later in this chapter.

life politics in so far as they have an impact on the reflexive project of the self. (p. 174-5)

Although many women participate in the contemporary non-institutional spiritualities, which are said to be more feminine, intuitive and even body-related¹¹, “...the relative social power and status of ‘New Age’ women remains an unresolved issue.” (Sutcliffe 2003:223) This seems to apply both to leaders and the lead. Indeed, during the writing of this chapter I was in personal conversation with a student reflexologist whose father was a doctor and who had been brought up in a strongly Christian family. She, however, was practising as a solitary witch. When I enquired why she did not belong to a coven, she told me that there was a great deal of sexual abuse of women in Pagan and Wiccan rituals and gatherings in covens and that also some Pagan leaders she knew abused their professional relationship with women. In her experience, the body was not valued highly in our culture.

Does the resurgence of spirituality in more populist forms such as NRMs address the issues that cause the stress felt by people in a consumer market-driven society? Might spiritual practices deflect from the real needs of people for social justice and offer mere palliation rather than practical solutions to problems in the real world? In NRMs, the emphasis is on private or personal psychological well-being to enable one to cope with loneliness, anxiety or depression at home or at work. Will learning to acquiesce through retreats, solitude, prayer and guided spiritual exercises or practices alleviate the source of suffering and woundedness?¹² I suggest that the newer spiritual movements do little to address, much less resolve, the structural and wider socio-political generation of oppression and personal or social distress, or even the ways spiritual practices may affect these. It can be argued that this may be particularly the case where spiritual practices are separated from the socio-political teachings and practices of which they are a part.

The first two episodes of the Channel 4 series *Spirituality Shopper* demonstrate vividly how spiritual practices are isolated from their inter-related cultural contexts

¹¹ I discuss contemporary concepts of spirit in Chapters Three Four and Five.

¹² Here I am thinking of books such as those by Henri Nouwen (1979, 1981) which concentrate on helping individual woundedness through solitude, silence and prayer. Another popular book is Scott Peck (1978) *The Road Less Travelled*, in which healing love and trust are characterised as ‘spiritual growth’ in traditional values’.

within the contemporary spiritual scene. Two young white women are offered the chance to try a variety of spiritual practices such as Sufi dance, Buddhist meditation, Yoga, personal sacrifice during Christian lent, communal meal preparation at a Sikh gurdwara, and preparing a meal for family or friends to celebrate Jewish Sabbath.

One of the young women finds work and life unfulfilling. She socialises, but it appears that she would like a male partner, evidenced by a throwaway remark at the end of her programme that she would like to set up a spiritual dating agency. The second woman is a thirty-four year old mother who seems to have unresolved grief for a recent miscarriage. With both these women, spiritual practices did not appear to address or resolve the wider social and personal reasons for their distress. One meditation practice however did appear to recognise the second woman's need for support in her grief. A Christian monk listened to the distress caused by her miscarriage and the deep questions the woman had about how a good God could have allowed such a thing to happen. It could be argued, however, that this practice integrated wider Judeo-Christian cultural teachings, where spiritual direction is combined with socio-political involvement. This is one of the important issues of contemporary spiritualities, where practices are divorced from their deeper cultural roots and teachings.

There is as yet little feminist analysis of why more women than men seek out and practise newer spiritualities (Sutcliffe 2003). However Jantzen (1995) argued that there is good cause for feminist concern about the way issues of gender and power are inextricably intertwined with new spiritualities, quite as much as older constructions. Although new spiritualities are open to women as well as men, and they can even be said to be feminine in terms of bodily and emotional relatedness, they appear to reinforce modern gender assumptions and to ignore the real questions as to why people are driven to seek solace in crystals or other privatised spiritual practices, rather than empowering them to allay anger and anxieties by challenging the systems and structures that govern their lives. Indeed, those who nurture their inner life through personalised spiritual practices can be said to support the status quo in workplaces and political systems which generate the anxieties and dissatisfactions. Jantzen (1995) sought:

...to warn of the dangers of the ways in which men of power whether in the churches or the universities have appropriated the concepts of spirituality, either by retaining their power but reserving them for male use, or divesting them of power and thereby domesticating and feminising them [and of] the danger of a privatised inward spirituality which soothes and tranquillises and promotes an inner harmony that is content to leave the public and political word as it is. (p.347)

Many more nurses in my study related better to contemporary views of spirit and spiritualities than to traditional religious accounts.¹³

Feminisms and spirit/body

So far in this chapter I have discussed the concepts of spirit and spiritual within their philosophical, religious and contemporary contexts. We see that there is a long history of the spirit-soul-mind as masculine, separated from the body, transcendent, and therefore superior to the physical body or the material earth. The construction of a disembodied, transcendental spiritual God that divided matter from spirit has been a central problem for feminist theology since separating spirit from body was said to be harmful and possibly illusory. Isherwood (1996) argued that “To suggest God is ultimately transcendent is perhaps the greatest illusion of all” (p.227). She argued for a rejection of “The Greek dualism of spirit and matter” (p.226). Similarly, Roman Catholic feminist theologian Radford-Ruether (1983) expressed the situation as:

...a pathological splitting of the mind or soul from the body [...] rooted in Greek and Christian androcentric dualistic ideology [...] everything that men have considered morally inferior or profane has been associated with ‘woman’ and the private world that she has been forced to inhabit. Embodiment (that is the nexus of nature, the material, emotion, feelings, sexuality, fertility, giving birth and suffering) has been symbolised as ‘the flesh’, the inferior world of the female which is to be transcended by the heroism of the spiritual - or relational, or existential, or scientific - male. (p.73)

¹³ I discuss this fully in Chapters Three, Four and Five.

As Jantzen (1995) summarised it:

To the extent that Christianity adopted a dualistic stance, and saw reason and the contemplation of the Good/God as a function of the spiritual in opposition to the physical, to that extent mystical union with God must be a possibility for women just as much as for men. On the other hand, to the extent that women are identified with procreation, the flesh and the material world, they are precisely part of what has to be overcome if spiritual progress is possible. Thus to suppose that women could be spiritual is highly problematic. At the very least, it is much more difficult for women than for men, since they have their own intrinsic nature to overcome, whereas men, being already identified with the mind or spirit, have a head start. Although in many respects Platonism made an uncomfortable fit with the doctrines of early Christianity, this tension in relation to gender issues was to a large extent incorporated into ideas of Christian spirituality. [...]. The tensions were compounded, already in Plato and throughout the subsequent tradition, by the fact that in both Greek and Latin (as in many modern European languages) 'soul' is grammatically feminine. Since, however, it is the male sex which is held capable of spiritual or intellectual activity, some peculiar convolutions of thought and expression result. (p.40)

Since it is with our bodily being that we experience life and relate to others and the world, Spretnak (1993) questioned why

...the dominant religious traditions are based on a spirituality that seeks desperately to transcend nature and the body, especially the female body. (p.267)

In the Christian Church, the body is both friend and enemy, reflecting the tension in Plato's philosophy as identified earlier in this chapter. Stuart (1996) wrote that:

Matter encased the spirit which did not belong to the true God. It was the spirit that Christ came to liberate from shackles of matter. (p.65)

Because women were identified with the body, reproduction and the material earth which had to be overcome in order for the Good to be achieved through contemplation with the spirit/soul-mind, it follows that women, the body and nature could, at least, be denigrated, or even abused.

Some women had been spiritual although in order to be such they effectively had to renounce their own womanly sexuality and body. Jantzen (1995:57) cited Ward (1987) in discussing how Pelagius was known as a (male) monk revered for (his) spirituality. After death, it was discovered that ‘he’ was a woman. Her fellow monks wanted to keep the secret of her womanhood away from the crowds, since both Pelagia and the father monks recognised that spirituality was for males or ‘honorary men’. But when the truth emerged, the crowds marvelled that God’s mercy was so great that a woman could be so holy and spiritual, demonstrating that it was a male preserve and not thought possible of women. Indeed scholars have demonstrated how spiritual practices were so thoroughly identified with masculinity if not men themselves that those women who undeniably were spiritual had to become honorary males. Those women, such as Pelagia, and also Felicity and Perpetua who were martyred for their spirituality, nevertheless thought of their spirituality in body-denying male terms. Perpetua wrote in her diary:

And to me also there came goodly young men to be my attendants and supporters. And I was stripped and was changed into a man. (Musrillo 1972: x)

Such a ‘sex-change’ as necessary for integrity of spiritual knowledge and practice was not only internalised by women such as Perpetua but also spoken of by Philo of Alexandria:

For progress is indeed nothing else than the giving up of the female gender by changing into the male, since the female gender is material, passive, corporeal, and sense-perceptible, while the male is active, rational, incorporeal, and more akin to mind and thoughts. (quoted in Costelli 1991:32)

Although in early Christian communities there was to be no distinction between male and female for as the apostle Paul wrote, all are “...one in Christ Jesus” (Galatians 3:28) in practice, everywhere there was. Daly (1983) argued forcibly that it did not matter what Jesus allowed or practiced. This questioning of the authority of Jesus has been a feature of radical feminist theologians, as they seek liberation from the bondage of masculinist imposed hierarchies of spirit/body, man/woman and

God/human. Robinson (1977) drew attention to the apocryphal account in the Gospel of Thomas where Jesus himself spoke of women needing to become male in order to enter the kingdom of heaven:

Jesus said, [to Simon Peter] 'Behold, I myself shall lead her [Mary] so as to make her male, that she may become a living spirit like you males. For every woman who makes herself male will enter the kingdom of heaven. (p.114)

Nevertheless, it is argued that in the patriarchal society of the time, the early Jesus movement did offer a greater chance for women to be more equal to men, and it is worth questioning why the apocryphal story from the Gospel of Thomas cited above was not included in the canon of the Christian New Testament. That there was a resurgence of patriarchal power in the developing early church, however, appears evident both within these same scriptures as argued by several eminent scholars whose work I discuss throughout this chapter. Where Paul's misogynist writings are taken as God's authority for all peoples for all times, rather than a reflection of the society of the times, women have fared less well than men. Women were to be silent in the congregations (1Cor.14:34-35) and be submissive to their husbands in the home as the man was to be to Christ as head of the church (Eph.5:22-23; Col.3:18). On the other hand, men were instructed to love their wives and women were also evident in leadership in the early house church, where Paul wrote, for instance, of Aquila and Prisca joining him in greeting the Corinthian church (1Cor. 16:19), and in the epistle to Timothy that women as well as men deacons must be "dignified, not scandalmongers, but sober." (1Tim.3:11)

With this extensive scholarly work, which I can merely touch on here, there is a range of interrelated concerns about the nature of the spiritual and woman and the body for feminists (Brook 1999, King 1997). In contrast to the separateness of spirit from body, feminist spiritualities, whether religious or non-religious, seek to reintegrate their bodily lived experiences and to bring these into a place where they are no longer marginalised, as Carr (1996) described it, by "a narrowly defined 'place' within the wider human (male) 'world'"(p53). It is grounded in embodied

experience rather than as transcendental disembodied spirit (Stuart 1996). Others however, myself included, prefer not to use an ethereal or other-worldly term such as 'spirit' or 'spiritual' since it is so culturally laden with religious ideas of transcendence and separation from the physical body, and indeed the world.. It is difficult therefore to define a feminist 'spirit' separated from the body as the focus is to overcome such a dualism. However, some scholars, such as King (1996), have suggested 'self', 'agency', 'identity', 'inner growth' or 'women's power from within', as the nearest equivalent to 'spirit.' Carol Christ (1986) charted the spiritual as transformative awakening, insight and wholeness, mutuality and interconnections between spirituality and sexuality.

Therefore, retrieval of the body, its emotions, sexuality and bodiliness as expressed in mutual human relationships and interdependence with the earth as body is central to feminist spiritualities (Spretnak 1995). As Carol Christ (2005) expressed it, life is not simply a physical bodily thing, but is holistic spirituality.

It is argued by dualists, however, that immortality is only possible if the soul or spirit is distinct from the material body and furthermore, that this dualism must exist in order to explain the immateriality of consciousness (Schumm 1995: 755).

In summary so far in this chapter in the arguments outlined it is evident that there are differing understandings of the concept of 'spirit', described as the breath which enlivens the body on the one hand to an immortal soul on the other, whilst it may also be considered as 'self', 'psyche' or 'mind'.

Furthermore, it is argued that the feminine, woman and bodily aspects of lived experience have been more holistic than masculinist constructions of dualistic body/spirit. I shall return to expand and discuss this later in the chapter. It is, however, the spirit as separable and transcendental to the body that is evident in the dominant discourse on spiritual care by nurses and it is to this I now turn.

Spiritual care and nursing care

Nursing care incomplete without spiritual care

Believed to be the first of its kind in the UK, the empirical doctoral study by Waugh/Ross (1992/1997) investigated nurses' perceptions of spiritual needs of

elderly patients in twelve National Health Service (NHS) hospitals in Scotland. It concluded that the spiritual

...supersedes all other values. It is the supreme affirmation of life. To ignore or attempt to separate the need to fulfil the spiritual well-being of a man from attempts to satisfy his physical, material and social needs is to fail to understand the meaning of man. (De Lorges 1980 cited in Ross 1997:6)

Ross cited the hierarchy of needs model developed by Maslow (1987) to define spiritual need as a progression upward, from a base of physical needs to 'higher' spiritual needs for self-actualisation.

Ross defined the 'spirit' as "the life principle; the soul; a breath of wind; essence; chief quality; that which gives real meaning" (p. 8) Although it was acknowledged by Ross and subsequent nursing researchers and writers that the concept was unclear, nevertheless the spiritual was agreed to give meaning purpose and fulfilment. Ross argued that meaning and purpose are considered important for recovery or a peaceful death (Henderson 1977). Hope is also a spiritual need, she argued, and important for either recovery or a peaceful death.

Furthermore, Ross argued that the spirit "is not bound by the same natural laws as the Body." These beliefs are also evident in the literature and background studies cited by Ross in this study, most of which are from America (Murray & Zentner 1975, Fish & Shelley 1978, Stoll 1979 1983, Yura & Walsh 1982, Carson 1989) and, in Britain, the evangelical Nurses' Christian Fellowship (N.C.F 1969) and Simpsen (1986 1988).

Ross found that those nurses most likely to identify and meet spiritual need 'at a deep level' were more likely to have an awareness of God in their own lives, whereas those nurses who saw spiritual care as the role of the clergy only gave spiritual care at a 'superficial level.' Some nurses said they had identified spiritual need but most felt unprepared to deal with it (Ross 1997). Whilst nurses traditionally included psycho-social and religious/cultural¹⁴ care within nursing care, the category 'spiritual care' was deemed separate to this since a nurse who regards the spiritual as

¹⁴These include cultural/religious beliefs about modesty, dress, diet and rituals related to life, sickness, dying and death which affect nursing care (McGhee 1991, Neuberger 1994, Schott & Henley 1996)

synonymous with the psychological would be neglecting the need to help the patient find meaning in life.

Information on patients' views of nurses' contributions to spiritual care were drawn from five small studies from the USA which showed patients viewed nurses' contributions to spiritual care to be mainly in terms of: 'being there', kindness, comfort, talking with them, understanding, a listening presence of the nurse, and contacting the clergy.

Nurses also mentioned these factors and included contacting clergy. Nurses in the study by Ross (1992/1997) also mentioned contacting the clergy and otherwise saw their role in spiritual care mainly in terms of: 'being there', kindness, comfort, talking with patients, understanding and a nurse's listening presence. Ross acknowledged the difficulties with generalising the study to Britain due to limits of size and time lapse of studies and cultural differences (Ross 1997, Greenstreet 1999). Nevertheless, she argued that nurses needed to have specific educational preparation to meet individualised spiritual needs using the nursing process of assessment, planning, intervention and evaluation (Ross 1994 1997a b).

Indeed it was argued by Ross that it was imperative nurses be taught to give specific spiritual care to patients, since, without it, nursing care was incomplete. This is similarly argued in the dominant nursing literature on spiritual care by nurses (Narayanasamy 1991 1993 1999a b, Harrison & Burnard 1993, Oldnall 1996, Waugh/Ross 1992/1997 1994 1996 1997a b 1998, Dyson Cobb & Forman 1997, Cobb & Robshaw 1998). Spiritual care is also said to be necessary even if a person is agnostic or atheist (Burnard 1988).

Nursing care is spiritual

In contrast to the study by Ross, the doctoral study by Bradshaw (1994) claimed that nursing itself is spiritual, as integral to the ethos of nursing, due to its historical and religious roots in the Judaeo-Christian¹⁵ ethical teaching of self-giving love. Here a

¹⁵These derive from the great commandment, or *shema*, that man's duty is to love and serve God with all his heart and mind and soul (Deuteronomy 6:5) and his neighbour as himself (Leviticus 19:18) on which all other Judaic teachings hang. This central OT teaching is pervasive of the whole of Hebrew thinking and can be seen throughout the OT (Lambourne 1963:26). It was therefore what Jesus taught since he was a Jew and not a Christian, as in Matthew 25:35-36: "I was hungry and you gave me food,

person cares for another human as if caring for God himself. This covenantal, *caritas* love had developed in Judeo-Christian cultures and was said to be the way the purpose of God was expressed in the world. Herein lies the relevance to nursing. Bradshaw traced the orthodox Christian view of man made in the image of God as being a unity, not a duality: "...the material body is not an object to be possessed but a living form which expresses and realises the self." (p.3). Bradshaw gives Jesus' teaching recorded in the Christian New Testament (NT) as highly relevant to the spirituality of nursing:

I was hungry and you fed me, I was thirsty and you gave me drink, I was a stranger and you welcomed me, I was naked and you clothed me, I was sick and you visited me and you came to me. As you did it to these the least of my brethren you did it to me. (Matthew 25:5-7)

In the latter sense, she argued, nursing *itself* is a spiritual service, lived out in compassionate care of the sick and oppressed. In this view, the heart of nursing was said to be patience, kindness, compassion, conscientiousness and other virtues of character in which a person may trust and have confidence (Bradshaw 1997a). Consequently, spiritual care by nurses to Bradshaw (1997b) was competent technical and practical nursing, given with respect for a person's dignity and attention to details of comfort:

The spiritual dimension of care is inextricably tied to the ethic of nursing. The spiritual dimension is not a separate aspect of care but it is the root from which 'care' springs. Hence I would argue that the spiritual care given by the nurse is different to that given by the religious minister. Spiritual care for the nurse is not so much talked about but lived out. (p.51)

This gives a sense of well-being through making the person feel secure and free from anxiety. Bradshaw continued that the religious values which had underpinned the development of Western nursing care had become replaced by contractual obligations geared more to the needs of the market and practitioner rather than

thirsty and you gave me drink, a stranger and you welcomed me, naked and you clothed me, sick and you visited me". It was these teachings on which Western nursing was based, as argued by Bradshaw (1994).

providing a caring service to the patient. It was this that had led to spiritual care becoming separated from bodily care, she argued, which has happened with the social erosion of religious belief and belonging. The remedy for this was, she continued, a '*Relighting the Lamp*' (Bradshaw 1994): in other words, a reversion to the ideals of Christian vocational service as demonstrated by Florence Nightingale would be the solution rather than adding spiritual care.

Attention was drawn also to the wider professional and ethical aspects of determining whose needs are being met in spiritual care by nurses. She identified that in order to deal adequately with questions of human meaning, a nurse needs to know about complex human cultural/religious philosophies, from Existentialism to Post-modernism. Although questions about the purpose of life are always a puzzle to human beings, and may cause distress in nursing the sick and dying, the meeting of these needs, she argued, is the responsibility of a religious minister, not a nurse (Bradshaw 1997b).

Other literature on spiritual care by nurses

As we have seen from the studies by Ross and Bradshaw there are different arguments about what nursing is and if spiritual care is required additional to bodily care. To Ross et al, spiritual care is a discrete category of care and greater than bodily social or emotional care needs. To Bradshaw, there is no need for spiritual care as nursing is itself compassionate, caring and competent. Whilst several authors¹⁶ have agreed with Ross that spiritual care is a necessity, rather than an optional extra, more recently a literature that questions this from scientific and conceptual bases is emerging. Henery (2003) argues both that the nursing literature dwells too little on why nurses should be involved with giving spiritual care and that it is:

Lacking coherence and depth and risks merging human with transcendent authority. Its use of scientific discourse lacks precision and clarity and

¹⁶ These include Burnard P. & Harrison J (1993), Clarke C. (1997), Cobb M. & Robshaw V. (1998), Dyson J., Cobb M. & Forman D. (1997), Goddard B. (1979), Golberg N. (1979), Long (1997), Martsolf M. & Mickley J. (1998), Narayanasamy A. (1991 1993 1999a b), Piles C. (1990), Reed P. (1992) and Wright S. & Sayre-Adams (2000).

risks intensifying those features of modernity which contribute to a loss of personal meaning in the face of death, suffering and loss. Nursing literature on spirituality raises important questions but is limited in its capacity to address them (p.550)

Paley (2002) talked of the “almost magical invulnerability” of researchers when they engage in “embracing philosophical gobbledegook” (p.33) which may render them immune to scientific criticism. This, he argued, is a disservice to nursing and in particular he relates this to those nurse theorists who make big claims for caring as significant in nursing. For instance, American nurse theorist Watson (1999) described nursing care as entering into the experience of the other, which, she claimed, has a spiritual metaphysical aspect to it since it transcends time and space. Watson (1999) proposed a model of caring based on transpersonal care as:

A person is more than a physical body but is interconnected body-mind-spirit with spirit as embodied in the physical but transpersonal, transcendent, an evolving consciousness, connected with nature and the universe;
There is a human-energy environment field – life energy field and universal field of consciousness or mind;
Caring-healing consciousness is primary for the caring healing practitioner;
Caring potentiates healing, wholeness;
Reintroduction of the feminine caring qualities into nursing and health systems - which have been excluded due to the dominance of objective scientific medical approaches - are essential in post-modern transpersonal caring models of caring-healing;
Caring-healing processes and relationships are thought of as sacred;
The world and individuals are thought of as interconnected, unitary consciousness cosmology;
Caring is the moral imperative for the survival of the planet;
Caring is as important for the planet as for health care systems such as nursing (p.129)

Here, Watson focused on the reintroduction of caring as hitherto excluded feminine activities. However, apart from claiming that the person is tripartite body-mind-spirit, she does not identify clearly how care of the spirit is different from or integral with body-mind care. Watson does however introduce post-modern notions of spirit as

being human energy and caring as being consciousness as well as moral, the intention being to bring healing.

All of these notions of spiritual care were relevant to my study since most nurses identified more with this view than with the Judeo-Christian views of spiritual care described by Ross et al. However Watson does not clearly describe how spiritual care as energy or moral or consciousness may be empirically applied by nurses and seems to adopt an 'other worldly' stance to it as transcendental to physical life. This led me to investigate literature on nursing care further.

To summarise, Ross and Bradshaw represent two very different Christian traditions in their respective theses. Bradshaw was a convert from Judaism to Christianity and her argument reflects the more body-affirming, ethical Judaic teachings. Ross, on the other hand, was from the charismatic Christian tradition, which emphasised the unique importance of the person and work of the Holy Spirit of God in saving an individual soul, or spirit. The contention by Ross was that spiritual care by nurses was essential and without it nursing care was incomplete. Spiritual care was described as quasi-religious, mystical and transcendental to physical life as well as traditional nursing activities of bodily care. These views are also presented in the subsequent dominant discourse on spiritual care by nurses. By contrast, the doctoral study by Bradshaw (1994) presented compassionate nursing care as itself spiritual. Indeed, a further category of care called 'spiritual care' was deemed to be beyond the professional competence of a nurse. In view of the anomalous positions presented by these landmark studies, I turn next to investigate studies of nursing care to see if nursing itself lacks something which would be remedied by nurses giving spiritual care, or whether nursing care alone is sufficient to meet patients' care needs.

Nursing and caring as gendered

Nursing as caring

The study into *The Value of Nursing* by the Royal College of Nursing (RCN 1992) highlighted that the special role of the nurse, both in the community and in hospital,

is to enable patients to feel cared for, and to reduce their anxieties, both in pain and in dying.

Whether nursing is an art or a science, or both, it is caring that distinguishes nurses and nursing from other professions (Abbott & Wallace 1990). The view that 'nursing' and 'care' are interrelated persists (Benner 1984, Leininger 1984, Watson 1985, Morse et al 1990, Lea & Watson 1996, McCance McKenna & Boore 1997, Cody & Squire 1998). Pearson & McMahon (1989) described nursing as a therapeutic intervention. The now famous definition of nursing as a unique art is that by Henderson (1960):

The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health (or to a peaceful death) that he or she would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. (p.30)

Empirical studies into patients' views of the qualities of a good nurse included personal qualities of kindness and friendliness in addition to the technical competence (Mason 1990, Evans 1991). Bradshaw (1997a) identified these as

...helping nurses to avoid reducing the human being to an object, separate from spirit of self and from the spirit of the wider universe. (p.117)

Nursing as women's gendered work

Traditionally, nursing is associated with feminine qualities of loving care and kindness akin to mothering, and a vocational sense of intimate involvement with bodily functions which most people would not want to be involved with. I want here to investigate the nature of nursing *work* which, of course, can be carried out by men as well as women. Nevertheless, although some 10% of nurses are men, a disproportionate number of them move quickly into managerial and educational positions¹⁷ (Salvage 1985, Bond & Bond 1986, Gaze 1987). This means that the 90%

¹⁷At the time of writing this thesis, 2005, it is men who are, respectively, the Dean and Heads of the three Schools in one of the largest universities providing nursing education in Scotland; the General Secretary of the Royal College of Nursing (RCN) Scotland; the National Board for Scotland, and the Chief Nursing Officer for Scotland, yet 90% of the nursing workforce and nurse lecturers are women.

of nurses who are women are not only providing the vast majority of practical care, they are also providing it over greater periods of time. This means that 90% of nurses are women who give practical nursing care and for longer in their careers (Gilloran 1995). It is argued that since caring in nursing is predominantly given by women, nursing care work is considered to be gendered (Lawler 1997, Miers 2000).

Where women are seen as nurturing, family oriented and caring of the health of others, this is often to the detriment of their own (Graham 2000). Moreover, feminist analyses have revealed there are unjust social, health and economic constraints especially on women. In nursing, gender implications have been recognised as being to the detriment of nurses, nursing and patients (Davies 1995, Lawler 1997) and of nursing practice (Webb 1986, Lawler 1991, Miers 2000). Despite the interrelated complexities of physical nurturing and other everyday activities, as well as emotional and social needs, which are central to nursing, the lack of scholarly prestige (Rafferty 1999) is said to affect nurses and nursing knowledge since the latter is not given the same legitimacy as techno-medical knowledge, traditionally a male domain (Katz 1969).

Gendered caring, patriarchy and spirit-mind/body dualisms

Gendered roles are described as socially constructed expectations of men and women (Oakley 1972) associated with the biological categories *male* and *female* (Walby 1990). The social construction is said to be due to patriarchal power and authority of a master over his subjects, especially women, children and subordinate males, “backed up by an appeal to the sacred” (Turner 1996: 148). It is literally ‘rule of the fathers’ which both as a word and a socio-cultural force is said to have roots which are inextricably connected with Christian traditions (King 1997). The argument is that as God is male, males are also believed to have God-like powers which create a false consciousness of worshipping masculine values (Daly 1983). This results in androcentric or man-centred world-views which are said to have developed out of dualisms of spirit/body. Carol Christ (1979) argued that women who are part of a culture dominated by patriarchal ideas and religion continue to be dominated by these values subconsciously, especially when under stress, even if they have

consciously rejected these in favour of secularism or other belief systems. Pateman (1988) argued that patriarchal values become part of the cultural psyche as 'fraternal' patriarchy which permeates social, economic, political, ideological and psychological aspects of individual and social life. Masculine domination of values is said to be internalised so that people become 'docile bodies': whilst they appear to choose such values voluntarily they are, in fact, passively dominated into acceptance (Bordo 1990). Consequently, secularism does not necessarily liberate women from masculinist, patriarchal power and, indeed, it is argued that women continue to be psychologically dependent and subordinated to male authority and men because this is woven into the fabric of the culture (Hampson 1990 1996). This includes caring and those who are carers in private and in public.

Caring work taken for granted in private and in public

Caring is said to be 'taken for granted,' or hidden, in social institutions such as marriage and the family where it is considered instinctive and therefore 'natural.' Indeed, it has been said to be innately instinctive for girls and women to care for others simply because they are female. This was evident in my study where participants perceived of their care as just something they gave and that such skills were instinctive, as demonstrated, for example, in their own daughter's innate caring ability. It is women who as mothers, daughters, wives, grandmothers and friends (Lister 1997) give everyday practical care of children, spouses, the sick and elderly. Such care is borne out of love and affection, duty and obligation (Graham 1984 Leonard & Speakman 1986) in addition to sustaining the physical, social 'kith and kin' and community fabric of life (Gerstel & Gallagher 2001).

The invisibility of caring in nursing

Caring in nursing is considered to be a public extension of woman's 'natural' womanly caring roles¹⁸ (Hochschild 1983 Sydie 1987). Such care is characterised by

¹⁸ The Secretary of State for Health, Dr John Reid, said in a recent radio interview that if nurses were in charge of the domestic cleaning of wards as they had been before the service had been franchised out to the private sector outwith the National Health Service (NHS), the cleanliness of the wards would improve and the incidence of hospital acquired infections (HAIs) would be diminished (Today, Radio 4 BBC 21/10/04). Whilst this may be true, the point here is that domestic cleanliness is still

virtuous, altruistic relationships of caring for the weak and helpless and has a religious sense to it, as Bradshaw (1994) argued.

Several nursing studies demonstrated the complexities of the issues of caring. Here I focus on how this care is gendered, invisible and undervalued. Scholars have noted how the skill involved in such care is both marginalised and presumed to be ‘natural’ in a predominantly female occupation.

Studies which described nurses as reticent and muted attributed this to the powerlessness of nurses relative to others who did not value, or listen to, them. Hart (1991) demonstrated in her study there was no appropriate language which nurses could use to express the more inter-subjective experiences of nursing interactions. She found that issues of power and powerlessness affected nurses’ ability to speak “because what they had to say is not valued by those in power and not listened to.”(p.21-2) Rather than being a matter of chance, this has been linked to gender imbalances “in which power relations dictate the way in which social reality is renegotiated between participants.”(Graddol and Swann 1989:126)

As with woman’s domestic caring in the family home, much of good nursing is usually invisible, unarticulated, undervalued in knowledge and monetary terms and literally ‘*Behind the Screens*’ (Lawler 1991). Lawler demonstrated how nurses were unaware of their skilful knowledge in their intimate care of a patient’s body and had no language to express such knowledge. She attributed this to the perception of nursing care as ‘natural’ or innate. Additionally, the length of time spent in bodily care, as well as the close proximity to another which this care engendered, contributed to acceptance of bodily care as innate. Lawler called this bodily care ‘*somology*,’ to show that it is indeed learnt knowledge, quite as much as any academic knowledge.

Whilst bodily nursing care has increasingly been demonstrated to require practical and emotional skill, the complexity of “emotional labour” (Hochschild 1983) in nursing has also been stressed by many commentators. Physical and emotional care is said to bring ‘closeness,’ The studies here enabled me to question if the closeness of

considered, even by those in very high positions, to be the role of nurses rather than doctors or indeed any profession allied to medicine (PAM).

intimate nursing care of another's bodily functions was 'spiritual' This was an interesting question for me to pursue in view of Bradshaw's argument that to care for the person who is a patient was a spiritual act, and Ross's opposing view that physical care alone was insufficient and indeed nursing care was lacking without specific spiritual care. This puzzled me so I decided to investigate aspects of caring and bodily experiences of selected illnesses further.

Several authors have examined the issue of emotional caring In '*The New Nursing*,' Salvage (1990) argued for 'caring for' physical needs as well as 'caring about' in the sense of emotional involvement with the patient.

Smith (1992) demonstrated the gender aspects of emotional care of patients in her doctoral study of student nurses' learning experiences, which draws on nursing and feminist literature. In '*The Emotional Labour of Nursing*' she described the way that emotional caring was largely untaught in the nursing curriculum, even in the 1980s, yet nursing students expected that was what they would learn to do as nurses.

Savage (1995) in her doctoral study '*Nursing Intimacy*', related proximity to intimate physical bodily care to an "existential 'closeness' which might be the grounds of a more metaphysical 'closeness'" (p. 123), said to be 'closer to the truth of that person's current dilemma'(p.352).

In a similar vein, James (1989) in her work with nurses and the terminally ill identified the physical and emotional caring in nursing as "...both being hard, skilled work, 'difficult' and even 'sorrowful'", but went on to argue that this vital part of nursing work remains "...undefined, unexplained and usually unrecorded due to its link with women's domestic caring."(James 1989:16, 20) The gendered nature of emotional caring in the private sphere and emotional caring in the public sphere of nursing is also emphasised.

These studies showed how the closeness and intimacy of care were vital to patients and nurses yet largely unarticulated and even unrecognised. The skills were 'just there', invisible and even 'natural'. Attention is drawn to the role of gender in this process of taking both bodily and emotional caring for granted. But were these aspects of nursing spiritual in the way Bradshaw had alleged, or was spiritual care

separate to these bodily and emotional and nursing care needs, as claimed by Ross et al? Whatever 'it' was, the caring process was largely invisible or taken for granted as 'natural'. Indeed, the largest professional organisation of nurses described the central role and value of nursing as "invisible mending" (RCN 1992:2). This was said to be:

... [...] intimate contact with patients to find out how they feel and to give them explanations that will remove anxieties that they dare not mention to other people. (p. 24)

Invisible 'being there'

Barnes (1998) discussed how nurses deal with people at their most vulnerable in many different settings on a daily basis. She argued that nurses should/must be educated about how to deal with "intimate contact" (p.42) with patients when they were at their most vulnerable and further claimed that this had not been adequately addressed in the reorganisation of nurse education development of the Project 2000¹⁹ (UKCC 1992). Furthermore, Barnes continued, a third mode of function, namely 'being', seems to have been entirely neglected in educational preparation for nurses. She cited Fabricius (1991:47) who argued that "...the nurse's ability to be with and for the patient is the most important way in which he needs her to be psycho-therapeutic" where psycho-therapeutic means "...the capacity of the nurse to help patients to bear feelings of overwhelming anxiety and distress." (Barnes 1991:44) A related argument is made by Lindholm & Raholm (1999) This is a small study of nurses' experiences of 'being there' with the suffering patient as times when nurses entered into deeply personal experiences of loneliness, grief and struggles and where nursing care was described as

...an expression of human love [...] not merely an abstract thought but is rather evident through tangible work, encountering suffering in real situations, a true being there. (p.528)

In this study caring was clearly fused with ethical practices and approaches derived also from the implicit Christian beliefs of the authors.

¹⁹ United Kingdom Council for Nurses (UKCC) 1984

Similar findings were demonstrated in another small study based on narratives of nursing care by seven nurses (Cody & Squire 1998), where good nursing care was perceived as 'being with' patients, sharing their experiences and demonstrating respect for their humanity.

The presence of the nurse to give time to, and be with, patients, thus showing appreciation of the patient's experience, was demonstrated as a key nursing function by patients and nurses in a qualitative study into closeness in nursing (Ersner 1991 1998).

Unless patients had specific religious/cultural needs, patients themselves described 'spiritual' care by nurses as being kind, competent and caring, as 'being there' 'comforting, doing something for me'. Where Clarke (1997) asked patients specifically what gave them hope and meaning they said 'nursing presence and care' to which relatives added 'competent nursing practice.'

In the studies above it was questionable if 'intimate contact', 'invisible mending', 'being there' or 'presence' could be spiritual, as Bradshaw (1994) appeared to describe in her study. If not, what was spiritual apart from this and for which nurses were to care as argued in the dominant discourse advocating spiritual care by nurses following Ross(1992)? And why was spiritual care necessary if both patients and nurses valued presence and 'being there' as 'invisible mending'? This line of questioning drove my research study.

Being and doing as practical caring

Despite the elusiveness of the concept of caring in nursing (Morse et al, 1990), nurses identified nursing care as practical doing and being (Davies & Lynch 1995). As Bradshaw (1994) argued, this gives a sense of well-being in body and mind through making the person feel secure and free from anxiety. Similar conclusions are drawn from empirical nursing research into the qualities of a good nurse, which include personal kindness and friendliness in addition to knowledge (Evans, 1991). Practical caring skills are also recognised as important to patients across a number of different care settings cross-culturally (Bjork 1995).

A King's Fund study (McIver 1993) summarised the cumulative research findings of what patients considered to be their primary concerns, whichever service they were

using. Their core concerns were: to be treated as a person, based on good communications and relationships with the health care professionals; and to be provided with good information to allay anxieties and ensure/facilitate effective treatment and care.

Self-abnegation in caring roles

Feminist analyses of caring have revealed unjust social, health and economic constraints on women especially related to their roles in nurturing family oriented caring for the health of others, which is often to the detriment of their own health (Graham 2000). Hochschild (1983) called this emotional labour deference, caring and serving the needs of others. Women's work has been constructed as feminine and in the private domain whilst men's or masculine work takes place in the public domain, which has important consequences for nursing roles.

The gender implications of nursing have been recognised as being to the detriment of nurses, nursing and patients (Webb 1986, Lawler 1991) and this affects the profession (Davies 1995, Miers 2000). Caring in nursing has little market value because it is perceived as women's natural role. Moreover, it is difficult to measure private acts in public terms. This type of care had already been recognised as limited by hierarchical bureaucracies in organisational structures of care (Melia 1987, Dingwall et al 1988). Davies (1995) argued however that if such care was neglected in deference to traditionally masculine bio-medical treatments, or other areas, patients and nurses lost out since no-one cared for the patient. This led her to describe the situation as *The Gender Predicament in Nursing*.

Lawler (1991) contended that the nursing knowledge and skill required for physical bodily nursing care was devalued. Despite the interrelated complexities of physical nurturing and emotional and social needs, which are central to nursing, Rafferty (1999) argued that nurses and nursing knowledge lack scholarly prestige compared to techno-medical knowledge, traditionally a male domain. Cash (1997) argued that

“Nursing operated within a patriarchal²⁰ system defined as one where there is domination by men qua men.” (p.142) whilst Savage (1995) reasoned that:

Failure to recognise nurses’ special skills has to be understood in the context of the social construction of nursing as women’s work. (p.126)

Additionally, when nursing care was given a religious vocational ‘gloss’ such as a form of self-abnegating loving service, this had negative effects on nurses and nursing. This process can be perceived in Foucauldian terms (1977) as a ‘disciplinary’ process of coercion, subservience and obedience (Crowe 2000). In this view of nursing, there is a sense of divine ‘mission’ to nursing work and the nurse herself is also perceived as being angelic, as depicted by Rose (1996), writing of her experience as a terminally ill patient:

‘Nurse’ who invariably enters without putting on lights is a supernatural being. She executes endless good works, and she offers her soul as well as her skill. She too has turned anguish into care; (p74)

Conversely Blum (1980) regarded caring as altruistic “...regard for the good of another person for his own sake, or conduct motivated by such regard” (p.9-10). In Blum’s view such caring need not entail self-sacrifice or self-abnegation, as has been traditional in religious perspectives of caring, such as those described by Bradshaw (1994). Blum contended, however, that religious caring could be said to be more for the sake of the God being served than for the sake of the individual needing the care, and this could render it less moral than non-religious caring.

This view is also developed by Passmore (1970). In writing about the history of Christian spirituality he argued that the approach to caring outlined above is basically against humanitarian ethics for if the welfare of human beings is only to be sought for God’s sake, rather than because of their own intrinsic value, this gives an egotism of spirit, which detaches people from real life concerns of care of others. Even love of people, he continued, is on behalf of, and for, this God, rather than an end in itself,

²⁰ For more on this see Goldenburg (1979) Ruether R.R. (1983) Daly M. (1983 1987) and Hampson (1996).

and so is inimical to a caring ethic. This therefore raises questions about nurses returning to caring with a sense of religious vocation as proposed by Bradshaw (1994).

Caring is slave morality

The virtuous ethical caring of Judeo-Christianity according to Paley (2002) made nursing into a slave morality especially enslaved to medicine. He identified

...an acute power gradient between doctors and nurses akin to that between masters and slaves in Nietzsche's genealogical narrative. Nurses are passive, timid, and powerless. They are at the beck and call of god-like, self-assertive doctors, who regard them as little better than useful parasites. (p.28)

Basing his argument on the slave/noble morality in Nietzsche's *Genealogy of Morality*, Paley argued that the medical model was "...soulless, objectifying, reductionist and mechanistic, lacking in care for the whole person." (p.28)

Importantly, Paley likened "nursing theorists of a particular stamp" (p.30) to the master morality of the priesthood against which Nietzsche railed. It is these theorists, he argued, "...who have concocted slave morality" (p.28). In Paley's view, "...the caring paradigm" is a new world-view expressed as the revolt of the slaves (nursing theorists) against the technical medical model, (p.30) where nursing is marked by absences:

Nursing becomes identified with the absence of 'phenomenology, the absence of science; 'holism', the absence of focus; and 'caring', the absence of clinical detachment." (p.30)

Here, instead, according to nursing theorists on caring, nursing is identified with caring as its unique purpose, which according to Paley typifies subjugated people or slaves. Devoid of any other power, the slaves invent a power base of their own which, however, may not be in their best interests. In other words, it perpetuates the slave/master morality with the slaves subservient to the masters, in this case science and associated objectifying clinical detachment. Consequently, no change is made to

the politics involved in maintaining the status quo of the master/slave morality, since, Paley continued, "...the fantasy revenge" of the slaves (nursing theorists) is merely a pathological displacement of will to power and moral superiority of nursing onto medicine. Thus, on this argument,

...the caring paradigm is simply an invention designed to invert medicine's values, and (by so doing) make nurses feel superior [...] [...] Officially it is an unqualified good, morally attractive and for itself. Unofficially, it is a way of satisfying the will to power, if only in the imagination of nursing theorists. (p.30)

In support of this argument, Paley cites nursing theorist Watson (1985) who argued that

...care and love are the most universal, the most tremendous, and the most mysterious of cosmic forces; they comprise the primal and universal psychic energy. (Watson 1985 cited in Paley p31)

This was, Paley argued:

...a kind of vicarious self-importance. It conveys the sense that in its attempts to outdo medicine in the fantasy competition for status, nursing is sometimes prepared to go to ridiculously self-congratulatory lengths. (p.31)

On this thesis caring is mystical and here I question if spiritual care by nurses could be evidence of further revolt against the dominant science of medicine. As a way forward for nursing as a noble profession in its own right, Paley argued that nursing needs to learn to do science, and that this should be the science of recovery and rehabilitation, rather than claiming caring qua caring is superior or 'tremendous' 'mysterious' because it is 'cosmic, 'primal' and so on. Paley's argument is that nursing science necessarily must include management of the wider environment - the psycho-social, as much as biological and technical. Whilst nursing cannot be only limited to dressing the wounds, equally, he questioned who would benefit if it took on what Watson (1999) recommended:

...new-age speculations about astrology, 'spiritual energies,' nonlocal consciousness, and holographic quantum concepts. (p.32)

The moral component of caring continued to be emphasised by others: they see it as respect for another's dignity and autonomy (Morrison 1992). Of relevance to my study also is the awareness of the reciprocity of cared for and carer acknowledged by ethicist and theologian Campbell (1984), who suggested what is needed is 'skilled companionship' within specified limits.

To sum up, it has been identified that the core of nursing is the patient feeling cared for. Whilst Lawler (1991) drew attention to the important lack of knowledge of bodily nursing care, other nursing theorists, Smith (1992) and Savage (1995), identified the importance of the 'emotional labour of nursing.' This consideration of caring demonstrates that caring is both a woman's role and that such care, whilst complex, is nevertheless 'hidden' and taken for granted in patriarchal institutions such as marriage and the family, as well as in nursing, where religious connotations further subjugate nurses and caring work. Such caring entails physical and socio-cultural nurturing. This care of the inner person is perceived as 'natural' and attributed to the gendered nature of caring as women's work.

There is debate about whether the virtuous nature of the nurse or nursing is in the best interests of nurses, nursing or patients, although without it the patients, like dependents in the family, may suffer. Whilst nurses may be closely or intimately involved in patient care, this is said to be 'invisible' or 'taken-for-granted'. Bodily care and 'closeness' of caring relates to Bradshaw's thesis that, given with compassion and competence, this kind/level of care is sufficient of a nurse. If nurses are to give spiritual care in addition, as argued by Ross et al, why should this be? Is emotional caring for the inner life perhaps the same as spiritual? Is it, in fact, taking place '*Behind the Screens*' (Lawler 1994) and so invisible? These questions led me to investigate this further: what is it nurses care for in bodily and 'emotional' care? Was it indeed necessary to add spiritual care as Ross (1997) et al insisted?

Caring for the person who is a patient

‘New nursing’ practice focuses on the holistic nature of nursing care in which there is an expectation of a “close, holistic relationship between nurse and patient” (Aldridge 1994: 722). Despite this, the teaching and practice of nursing remains divided into specialisms of physical, mental, or community care, as well as numerous subdivisions within these categories. Moreover, individual nurses and the people for whom they care are concerned with perennial human questions about what human life is (Bradshaw 1994). These questions are sharply focused in caring for dying people, when nurses, as others, question what happens to the person, or self, who is dying or has died.

‘Spirit’ as bodily self?

‘Self’, in a philosophical, existential²¹ sense, was described in a study by Copp (1999) in her doctoral study of experiences of nurses and patients in *Facing Impending Death*. This was discussed in the context of literature on psycho-social grief coping mechanisms. She explored how patients and nurses consistently separated the self, or person, from the body in dying and how loss of self was of great importance to patients. Nurses used this as a way of assessing how near death was for individuals. Patients used this process in, for example, talking of their funerals. Nurses and patients experienced difficulty in talking of the body and the inner person as distinguishable when death was near. This brought a metaphysical ‘closeness’ between nurses and patients (p.123). Copp demonstrated a process of separation of the self from the dying body as an existential “loss of self,” (p.206) where the body was spoken of as separate from the self (p.208). She proposed a conceptual map of four modes of dying: person ready/ body not ready; person ready/body ready; person not ready/ body ready; person not ready/ body not ready. This might suggest that the two are separable, although Copp attributed these mismatches to patients’ ‘holds’ on physical, social and psychological attachments on the one hand, and their rapidly

²¹ Existential is a complex term from philosophy, reflecting the inherent paradox that life is meaning but also that meaning is life. There are many expressions [of this idea], but that an individual exists uniquely rather than as an abstraction of universal ideals is central to this humanistic philosophy (McBride W.L. in Audi R. *Cambridge Dictionary of Philosophy* 1995; 255-6).

deteriorating bodies on the other. However, divisions between body and an inner self were evident.

The idea of considering the body-as-self and body-as-object is the outcome of a study of how five doctors reframed the body during physical examination. Young (1997) considered the way in which the body was objectified through examining body organs whilst, nevertheless, acknowledging the presence of the person. The tendency was to refer to the organ as if it was something other than the person, whilst, in surgery, the subjective person was drained from the anaesthetised body as comments made reflected an absent person. On the other hand, in post-mortem, a doctor could assume a person remained in the corpse as he or she was addressed positively or negatively. This perpetuates the problem of whether the self is identical with the material body or is separable as in self or person in Cartesian mind/body dualisms.

Doolittle (1990) in her doctoral study of patients' experiences of stroke described how the sense of inner self was dramatically altered by the loss of physical bodily wholeness. When a limb was paralysed there was a sense of this diminishing the perceived sense of self. Patients spoke of limbs in a detached manner. During recovery there was a sense of struggle between the mind or brain and the body with a sense of the mind (as subject) controlling the body and mind over the body (as object). This echoed centuries of philosophy and biology in which the body was seen as merely a machine subordinated to the brain. Although this reflected a Cartesian dualism of body/mind, nevertheless the lived experience of the stroke was a bodily experience, a body event not a brain event, in which the arm or leg weakness was the stroke. Meaning, therefore, is found in and through bodily recovery and reintegration into former social life-worlds which differed from the neuroscientific location of the stroke as pathology in the brain. This led Doolittle to conclude that:

We don't *know* our habitual body rather we *are* our habitual body, knowing relegates it to a conceptual form of representation. Instead we have culturally determined pre-reflective bodily capacities. (p.157)

Discussion

Although the studies above are not specifically about spirit or spiritual care, they show how a person perceives of themselves as an integrated whole, even when affected by illness such as a stroke. Stroke is experienced in the whole body. Furthermore, they demonstrate how dividing the lived experience into two, such as body/mind, is to objectify the person. These studies indicate some of the ways nurses who care for people as whole persons nevertheless face dualisms of body/mind or self. They also advance the question of whether caring for the body and inner self, psyche or person is sufficient or whether additional care of a supernatural spirit, transcendental to material bodily existence, is necessary, as Ross et al claimed. Furthermore, the contemporary focus on the importance of the body in constructing the self (Shilling 1993) could be said to perpetuate the dualisms inherited from body/spirit-mind oppositions identified earlier in the chapter. For instance the idea in the sociology of the body “as a vehicle of the self” (Turner 1996:68) presupposes a distinction between subjective self and material body. However, these social developments in late twentieth century Western cultures, along with the emphasis on self-development of the individual self based on choice as a consumer, contribute to the demise of a Hellenised Judeo-Christian tradition of body or flesh opposed to spirit or mind (Turner 1996).

Pain confounds body/mind dualism

In a significant anthropological study into pain and meanings in the body in a study of torture and abuse victims, Jackson (1995) identified that where people try to cope with pain as ‘mind over matter’ or ‘matter over mind’, the pain confounds this body/mind dualism because it is both physical *and* emotional simultaneously, rather than caused in either the mind or the body before being experienced. A Cartesian legacy of dualism which fails to describe the person’s lived experience was evident (Schutz 1971 in Jackson, 1995).

Jackson also argued that an ‘embodiment’ approach viewed pain as lived experience in the body: to talk of *emotional pain* is to disembodify it, and this is not what pain actually is. Even emotional pain is felt physically so that separating emotional pain from physical pain is not a valid reflection of people’s pain experience. But that pain

is a lived experience of embodiment is not acknowledged in bio-medical treatment when, for instance, pain is located 'in the brain.'

On the other hand, people in pain themselves objectify pain descriptions. Jackson went on to suggest that there are difficulties for people as patients in articulating experience in language with nurses, whereas the experience is 'understood' by and with those people who have similar experiences. People with chronic pain struggle with its meaning partly because they have been socially conditioned to perceive pain as a physical sensation, Jackson observed the extension of the person into the culture and vice versa. Bodily-being is situated in a cultural or social context and is therefore based on perceptions of the senses which cannot be independent of the body.

Here I am investigating what it is nurses are to care for in spiritual care, for if it is the soul/spirit of religious discourses as suggested by the dominant nursing literature advocating spiritual care by nurses then this is very different to the care of the embodied self and the bodily or material self. If meaning, as well as purpose and fulfilment, or meaning purpose and fulfilment, is the definition and function of the spirit, as Ross et al claimed, it is important to know if people find this in transcendental spirituality or in material bodily life, or perhaps both.

Meaning in self-as-body

Individual meaning is said to be embodied in the material body through the senses (Csordas 1994). As argued by Merleau-Ponty (1962) the senses are embedded in the body. They should not be regarded as cemented onto the body as a Cartesian view of the body might suggest, but as fluctuating between the two. In this phenomenological view, the body-subject is experienced existentially through language, motions and gesture, and not transcendently. In other words experience is bound to this world, rather than separated from it, and we encounter a unified self rather than one divided into self-soul and body which are inseparable although separated theoretically in philosophical and theological discourses. Thus psychological continuity is not independent of the body but is the embodied self. If the self is literally physically embodied, then the self as embodied may be indistinguishable from the spirit. This is of course debatable in philosophical and theological discourses, as mentioned briefly at the beginning of the chapter. On the other hand, the sociological perspective of

personal identity differs from biological bodily identity in arguing that the self is not dependent on the biological body but on the “coherence of memory and consciousness.” (Turner 1996:62)

If the self is embodied material stuff then what is this additional spiritual need? How does spiritual need differ from embodied memory of self and others, if at all? If there is indeed a spirit or soul which Plato and some religious people believe, where is it in the body and is it an entity in itself? If not, then what else is spiritual need apart from care of the innermost person? These are complex questions which are not the purpose of my thesis to answer. Nevertheless, consideration of their complexities is very important in investigating why nurses are asked to care for the spirit as well as bodily and more subjective care.

Self as embodied memory

Evidence from neuroscience is that the personal self is constituted by bundles of memory in the brain cortex in relationship with the environment and others (Greenfield 2000). Greenfield argued that meaning is constituted around and within bodily experiences, i.e. the inter-relatedness of physical body exterior with inner physical body e.g. brain. It is the brain that constitutes the self and the self is arguably nothing more than natural, physical biological brain mechanisms which are expressed as language.

Greenfield argued that if self is literally physically embodied, memories of events constitute the person and cannot be separated from the body. If the bundles of memory traces are destroyed, as in Alzheimer’s dementia, then the person also goes, as there will be no self distinct from the brain functions. On this argument, there was no transcendental spiritual meaning beyond the physical body, just material, bodily stuff. The idea of there being something different to our consciousness, a ‘Cartesian theatre’ (Brok 2003), with a self looking on at our own consciousness, would involve a ludicrous series of infinite regression of onlookers who could view the self: so the self or the soul would be merely an abstraction (Dennet 1991). In turn, these mechanistic actions constitute a socio-cultural existence of the self. As Dennet contends: “Each normal individual makes a *self*. Out of its brain it spins a web of

words and deeds.” (p.416) Even the creation of a personal self from stories and personal history was biological in form and function (Brok 2003).

Hume (1739), the Enlightenment sceptical philosopher, had argued that the existence of matter or stuff - that is our physical bodies - in time, is all there is.

Out-of-body

Moving briefly to consider out-of body-experiences as in Near Death Experiences (NDEs) during cardiac resuscitation, the person describes the self as hovering above the body which is being resuscitated, giving a sense of body/spirit separation. Alternatively, the person describes an out-of-body experience, typically going through a dark tunnel towards a beckoning light, which appears to give peace and comfort:

Hovering beneath the ceiling, I looked down
Upon a body, untenanted, my own
Strangely at peace, airy, weightless as light
I floated there freed from pain-filled days and nights
Until a voice I heard, an urgent call,
And again I dwelt within my body wall
(Sabom 1982:21)

The NDE can be so powerful that people can believe in a part of themselves which is separable from the body. After having an NDE himself Ayer (1989) acknowledged being more open to the possibility of an afterlife. However, he maintained his atheism since an afterlife is possible without a God, as is evidenced in reincarnation philosophies (Samuel 1999). NDEs give nurses and patients concerns about the relationship between the body and the person.

Discussion

The literature above on people who are dying, or have a stroke or have NDEs demonstrates the lack of clarity existing in nursing practice about the nature of the person whose body is affected. This has implications for nursing education in spiritual aspects of care. Do people need specific spiritual care as separate from the body (Ross 1997), or is nursing care sufficient, as argued by Bradshaw (1994)? Why

is it problematic to see the body as the person for whom nurse care and is this less important than an inner person or 'spirit,' however defined? Other nursing literature has attempted to analyse this conceptual confusion. Long (1997) in her analysis of spiritual care in nursing suggested 'self' as 'spirit,' but then she suggested that to understand how a patient thinks or feels a nurse has to care for the spirit as well as the psychological areas.

Golberg (1997) in her concept analysis moved toward defining the psyche, or mind, as spirit. She refined the categories into two concepts: physical and emotional/spiritual and concluded that to split the psyche from the physical and label one 'spiritual' was inappropriate as the original definition of 'spirit' means 'that which enlivens the body'. Her analysis suggested that the spirit is part of the body as psyche, but then, citing Stoll (1979), she viewed this as transcendental to the body, although *through* the body. She described spirituality as integrative energy giving connectedness and harmonious relations, both between different parts of a person's bodily being and with others, which may diminish in illness. There were similarities between related concepts such as love, touch, presence, empathy/compassion and healing which she argued could be emotional/spiritual or physical. However she found that most of the nurses to whom she spoke did not think spirituality was of any relevance to them as nurses, and she also observed that the nurses put all the differing characteristics, such as touch and presence, into action on an 'unconscious' level. This finding links well with feminist analyses of caring as 'invisible'.

To summarise this chapter so far, I have briefly discussed concepts of spirit as breath, soul, mind or self as separated from the material body which arguably have negative effects on women and the body.

Studies of caring, nursing and related research suggest that the self is embodied memory as mind, self or person and that this gives meaning to individuals. These studies demonstrate difficulties in both recognising what was spirit is, distinct from self as embodied meaning, memory, mind or psyche, and in caring recognised as legitimate knowledge. However these studies still do not indicate why spiritual care should be expected of nurses.

Caring in nursing is seen as a public extension of gendered caring, where intimate caring of bodily needs of another, whilst invaluable for sustaining individual and community life, is 'hidden' or unrecognised. As such, bodily caring is deemed less prestigious than work constructed as masculine or men's work. Furthermore, socially constructed patriarchal power subordinates women and caring to masculine public interests.

As gender has been demonstrated as important in nursing and caring I wondered what role gender played in this new development of nurses being expected to give spiritual care. This led me to explore literature where spiritualities are examined from feminist perspectives. Since no study was found in the nursing literature I turned to literature in feminist informed theologies and spiritualities.

Feminist informed spiritualities and theologies

Because the focus of my research is to understand why nurses are asked to give spiritual care as well as bodily care, the construction of spirit/body hierarchical dualisms and effects of this have been central to this chapter. Earlier in this chapter I indicated difficulties with divisions between spirit and body and the effects of these on the body and women. Since it is from such a world-view that the argument for nurses giving spiritual care is derived, I explore this further here within the disciplinary context of feminist informed spiritualities and theologies

It appears that the construction of a disembodied, transcendental spiritual God that divided matter and spirit, interrelated with gender and power, has been a contested debate by scholars in theology and religious studies for over thirty years. Already we have seen how in philosophy the spirit-mind had pre-eminence over the body associated with women and the earth, or nature, as well as those deemed 'other' than the dominant men who practised spirit-mind activities, such as philosophers and religious officials. It was argued by several scholars that this critique extended to traditional religions such as Christianities. Moreover, newer spiritualities appear to continue separating the spiritual from the physical and social worlds and, indeed, to offer spiritual practices as means of solace and escape from life's stresses and

sorrows whilst resolving little of the underlying personal and political causes. Here I return to explore this further within the disciplinary context of feminist informed spiritualities and theologies.

The dominance of masculinist constructions of human realities through writing and then interpreting, translating and teaching religious texts such as the Bible has had a great deal of influence on socio-cultural attitudes especially to the body and women (King 1997). Although significant inroads into challenging such authorities continue to be made, it remains the case that much needs to be done to dismantle the hierarchies of the dualistic worlds of spirit/matter, men/women and culture/nature. For instance, in April 2004, the star Britney Spears was reprimanded by the male leader of the American Baptist church because her film acting scenes are overtly sexual and said to be inconsistent with her religious beliefs and church membership. Does one hear similar criticisms of men actors? Not only is it more likely to be the case that women in all walks of life, and especially in religious circles, should have their sexuality and bodies controlled by man-made texts and teachings, but their opportunities to practise public, spiritual or religious/cultural functions also continue to be limited because of their biological sex.

A woman canon in the Church of England (Maltby 2004), writing of the anniversary of the tenth ordination of women to the Anglican priesthood, highlighted the fact that women are still not allowed to become bishops in this tradition. Maltby continued that it is not the general public who are against women, for a majority have shown their support. It is the institutional church that is actively against the appointment of women to higher office. This when, as Maltby points out, it is obvious "...we are not awash with talent in the [male] episcopate." Meanwhile, women priests are to "...give complete loyalty and commitment back to the church" (p.25). This perpetuates gender hierarchies where women are not allowed to be promoted to higher office and remain subordinate to men. In the Church of Scotland, whilst women have been ministers of Word and sacrament for many more years than their Episcopal sisters, it was only in 2004 that the first woman, Dr. Alison Elliot, became Moderator of the Assembly. Why should this be?

Patriarchal constructions of spirit/body

It is said that separation of the spiritual from the physical or natural is a construction associated with patriarchal religions (Daly 1973, Hampson 1990 1996, Shaw 1996, King 1997). The situation that feminists critique is described by Ballou (1995) as

...shaped by the patriarchy to make the spiritual separate, beyond natural, and arranged in hierarchical relationships [such as those who know about spirituality] transcend ordinary life [and are seen as] special, better than and separate. (p.14)

It is further contended that divisions of life into hierarchies of matter and spirit, private and public, serve white male power and have been a source of oppression of women, the physical body, the earth and other races and cultures (Daly 1973 1979, Radford-Ruether 1983, Schussler Fiorenza 1983, Hampson 1990 1996, Jantzen 1995, Puttick 1997). Radford Ruether (1983) described anthropologists who have found that:

Most human religions, from tribal to world religions, have treated women's body, in its gender specific sexual functions, as impure or polluted and thus to be distanced from sacred spaces and rites dominated by males. Female blood shed in menstruation and childbirth has been a particular focus on this definition of woman as polluted, over against sacrality. (p.7)

Whilst a similar critique is made of eastern religious-cultural practices (King 1997, Ballou 1995) and many contemporary or new religions (Puttick 1997, Sutcliffe 2003), as with the rest of this chapter I focus my discussion around Judeo-Christian traditions.

Spirit holy/body sinful

It is argued that a male view of spirituality as holiness which is contemptuous of the body and woman can be traced to patriarchal texts in the Bible, as in the second of the two mythic accounts of the fall (Genesis 2:4-25). Here woman is portrayed as the

cause of man's fall into 'sin' ²² (Loades 1990, King 1997). As such, women and the body had to be controlled by men and the Church, which had an irrational fear of women for her alleged propensity to lure spiritual men away from 'higher' pursuits. "The flesh, the female had to be overcome if the spirit was to grow." (Jantzen 1995:55) Indeed, as discussed earlier in this chapter, spirituality has been equated with maleness for most of the history of Christianity. This was traced to the third and fourth centuries when mystics who retreated to the desert to seek holiness defined spirituality in gendered ways; which was subsequently developed as a dominant strand in Christianities.

Although spirit-mind was without gender, or as grammatically in the feminine gender, as we saw in the definition and discussion of *ruah*, earlier in the chapter, spirit-soul/mind has been identified as masculine and both spirit and men were to become superior to the material body, the feminine and women. As Jantzen (1995) commented:

Clearly spirituality is thought of as a domain reserved, if not for men only, then at least only for manly spirits, whatever the sex of the body. (p. 52)

Whereas men had to be detached from physical living activities of the body or the flesh, to achieve 'higher' spiritual goals, women were considered only capable of bearing

...children and not able to engage in pursuits of mind-spirit. Reason and the principle of life are linked together and identified with maleness; the female is associated with bodiliness, the clouding of the mind, and passivity. These linkages would have a very long run in the history of Christianity. (Jantzen 1995:30)

²² The argument is that in the biblical mythic story of the fall (Genesis 2:4-25) Adam had been tempted by the woman, Eve, and fell away from the greater spiritual good God had ordained for mankind. Thus woman, the body and sex were culturally and religiously rendered inferior to man and mind-spirit: it was through the latter that mankind reached great heights of meaning in life and death whilst, if succumbing to the temptation of woman and 'the flesh,' he would fall from divine grace. For more on this see Ruether-Radford R.(1983:73) *Sexism and God-talk Toward a Feminist Theology*, London, S.C.M. Press; Goldenberg N.(1979) *The Changing of the Gods*, Boston, Beacon Press; Tribble P.(1978) *God and the Rhetoric of Sexuality*, Philadelphia, Fortress; Gardener A. (1986) Genesis 2:4b-25 "A Mythological Paradigm of Sexual Equality of the Religious History of Pre-Exilic Israel?" in *Scottish Journal of Theology* Vol.43, 1-18.

These ideas are evident in the Christian New Testament (NT) and have had dominance in the teachings of the Christian church up to the present day²³.

For example, the influential mediaeval church father Aquinas (c. 1225-74) thought that, although the soul needed the body, the part that is everlasting and which abstracts knowledge from the body/matter "...is the soul or intellect which is spiritual which alone images God, whilst the soul can exist without the body" (Stuart 1996:67) Here there appears to be accord with Hellenic philosophy such as that of Plato as discussed earlier in this chapter.

Goldenberg (1979) argued that the early Christian church fathers despised fleshly woman due to her biological bodily functions of bloody menstruation and messy childbirth. In contrast, virginal woman was idealised, as was the Blessed Virgin Mary (BVM), who was believed to have conceived through the Holy Spirit rather than sexual intercourse, and also as the mother of the male son of the male God.

Silenced women

Pagels (1976) argued that because the traditions and activities and sexual being of women were perceived as a threat by the early Church fathers, when these men transmitted and redacted the formation of the canon of the Christian New Testament and Church law (ca.200 C.E.), female imagery for God was left out. This andocentric process made women's knowledge "irretrievable" in history and according to feminist theologian Schussler Fiorenza (1982)

...most of women's early Christian heritage is probably lost and has to be sifted out from androcentric early Christian records. (p.40)

Writing on how women were marginalised and made invisible in the androcentric "mind-set" of the patriarchal NT, Schussler Fiorenza (1982), said:

²³ For instance, in February 2005 the synod of the Church of England continues to debate whether to allow women to be bishops which threatens to divide the church between liberals and fundamentalists.

Oppressed people do not have a history. They remain invisible in the reality construction of those in power. (p.32)

King (1997), as well as other feminist researchers, demonstrated that knowledge of women's experiences has been left out, or silenced, in the histories of all major religious/cultural histories, created by and for men.

Radford-Ruether (1983) described this silencing process as being in men's best interests since, if women are usually silent and silenced²⁴ and do not speak for themselves, they adopt the discourse of the men who founded the religion.²⁵ Ruether (1998) described these as disabling hierarchies, whereby women submit to the mediations of a man in whose service they sacrifice their lives for his love.

Daly (1983), a radical post-Christian²⁶, said we need to be liberated from the masculine discourse of Christianities. She argued that this discourse is so pervasive of our societies that we accept the language and symbols of their phallocratic value system. Consequently, we inject these values into ourselves and into society as fraternal patriarchy²⁷ so that they become a web of self-fulfilling prophecies. Instead, it is argued, we should castrate these masculine ideologies of their potency because they are "basically oppressive and must be rejected." (Daly 1993: 10)

In similar vein Hampson (1996), a post-Christian theologian, rejected the view that we are both body *and* spirit and that the spirit needs to soar above the world and bodily experiences to be in a relationship with a male God who frees us from

²⁴ Silencing women by the power of male priestly hierarchies continues in 2005. Eminent academic feminist theologian Dr Carol Christ was prohibited from speaking at a prearranged event in Australia because it was thought her challenge to orthodox masculine religious views was unacceptable (<http://www.abc.net.au/rn/talks/8.30/re/rpt/stories/s1319351.htm>, accessed 24/03/05).

²⁵ In order to become equal in any way with men, women had to become honorary men, much as they still do today. By becoming asexual they had the right to develop and teach spiritual practices, something which the Catholic Church reserved for holy celibate men (Jantzen 1995).

²⁶ 'Post-Christian' was first used by American theologian Mary Daly in the 1970s. It describes those people, mainly feminist women theologians, who have left the Christian church because of its androcentric teachings and doctrines. Although Daly and others now do not use the word 'Christian' at all, others acknowledge their Christian heritage. In Britain, Hampson is said to be the leading post-Christian theologian whose work *After Christianity* (1990) argued against the uniqueness of Jesus in history due to his alleged miraculous virgin birth and resurrection. Since these events involve breaking the laws of nature they are challenged by feminists, not least because it sets up unhealthy hierarchies between spirit and matter, especially women and the body. Whilst post-Christians may allow god-theology, Christian theology is said to be irredeemably patriarchal and linked to venerating the past and the Bible which reflects men and their interests at the expense of women and the earth. (Isherwood 1996:180-182).

²⁷ I have already included discussion of this above (Pateman 1988).

existential *Angst*. Christian theology's idea of God being 'out there' Hampson argued is typically phallic male thinking. God is, in other words, a projection of their maleness. It teaches people to define themselves in relation to an external male Father-figure as Lord, Saviour, Master, and so become like a detached, autonomous, male god. This sets up a power imbalance based on masculine power ideologies and feminine passivity. Hampson also argued woman is disempowered and subservient since

...there is no sense that the self, secure in itself, can freely exist, in easy intercourse with others. We cannot maintain ourselves; we are insecure.
(p.218)

Hampson (1990) further argued that the classical male teaching of Protestant Christian theologians was damaging for women's sense of a unified self, and so was bad for women's (and men's) health. She continued that:

...to be a Christian means that one has a radically different sense of oneself, a sense of oneself as being bound up with God and what God is.
(p.215)

Refeminising the spiritual

We see from this brief résumé of the contexts of the concepts 'spirit' and 'spiritual' that the feminine, woman and bodily aspects of lived experience have been ignored or suppressed. However those feminist scholars who have remained Christians have endeavoured to retrieve scripture and traditions from dominant patriarchal dualisms. Slee (1996) reconstructed the text to effect a narrative recreation of self between the text and the reader.

Phyllis Tribble (1982) endeavoured to find new ways of conceptualising the divine within Judeo-Christian scriptures by highlighting lesser known metaphors for God as a mother who gives birth (Deuteronomy 32:18) and as a midwife (Psalm 22:9-10) Whilst Jesus is compared to a mother hen who broods over her chicks as he laments over Jerusalem (Matt.23:17), God is sometimes portrayed as a mother:

Can a mother forget her sucking child?
that she should have no compassion for the son of her womb? (Isaiah 49:15)

Here though, as throughout these scriptures, it is a son who is in the mother's womb, never a daughter, hence adding more evidence from within the texts of an androcentric bias.

Sally McFague (1987) also portrayed God as mother and incorporated the interrelationship of the world and God, rather than the separate dualism of material/spiritual spheres seen in patriarchal images of God as ruling over His creation. Moreover, she pointed to the world as offspring, in which the Mother God affirms the existence of the world which is her body. By undercutting divisions between body/spirit-mind within traditional Christianities, and arguing for bodily health holistic, McFague also described God as healer.

Soskice (1996) argued that "...women not men are suffering servants and Christ figures" (p.30ff) whilst Hopkins (1990) and Eisland (1994) also appropriated the story of Jesus as the God who conquered all, even suffering and death, as helpful for those who are disabled.

Althaus-Reid (1996) argued for Jesus as the divine co-sufferer whose embodied spirituality breaks down the barrier between the transcendent, and physical where also concrete action for liberation "...empowers [women] in situations of oppression." (Shaw 1996: 52-3)

Tatman (2001) offered a useful summary of leading Christian feminist theologian Radford-Ruether:

Underlying this feminist Christian theological paradigm are three primary metaphysical presuppositions: that of the full, unqualified and embodied humanity of all men women and children without exception; that of the inherent integrity of all non-human creation; and that of the finite character of all earthly existence. Associated with this last supposition is the rejection of the notion of eternal life, a heaven above, and the idea of a new creation brought into being by an omnipotent, transcendent, wholly-other deity. Above all else, in this paradigm the finite matrix of existence is valued for its own sake. (p. 152)

The feminist theologian above can be said to 'redeem' the divisions of body/spirit from within the androcentric texts. Others however pursued ideas of the spiritual as post-Christians, divorced from Judeo-Christian traditions. I turn now to discuss features of contemporary feminist spirituality which seek to overcome the matter-denying thought-worlds of dualistic Christianity.

Beyond dualisms of body/spirit man/woman

In contrast to the separateness of spirit from body, feminist spiritualities, whether religious or non-religious, seek to reintegrate their bodily²⁸ lived experiences and to bring these into a place where they are no longer marginalised in "...a narrowly defined 'place' within the wider human (male) 'world'" (Carr 1996:53). Instead, they try to end oppression, especially of women and their bodies and to work toward a sense of wholeness (King 1997). This earth-bound, secular, eco-feminist spirituality (Warren 1993) includes many personal and social experiences of work, gender and the environment which can empower women to seek a new awareness of personal, social and political liberation as a person, here, in this world (King 1995). Radford-Ruether explicated the threads of liberation²⁹ in Judeo-Christian scriptures which, she argued, are valuable for women's liberation from unjust hierarchies and subordination to and by men and their religious teachings.

Emphasis is therefore placed on the interconnectedness of the human body, particularly woman's body, with the body of the earth, recognising that domination of both have been part of patriarchal dualisms (Spretnak 1995). Related to this, constructions of life into hierarchical dualisms: spirit/matter, male/female, mind/body, supernatural/natural and spirituality/sexuality are rejected (Slee 2002). Life is not however only an internal matter for an individual but social and political,

²⁸ Even for non-feminists in the secular world the body is seen to be identified with the self, described by social theorists as the reversion of traditional Christian dualisms of spirit/body as the self *being* the body (Shilling 1992). The body became the "object of salvation which has in its ideological functions replaced the soul" (Baudrillard 1970 cited in Turner 1996 *The Body & Society* p35).

²⁹ Liberation theology is already a strong tradition within Judeo-Christianities. However Althaus-Reid (2003) argues even this is masculinist and has made matters worse for poor Latin American women.

reflecting the original feminist mantra ‘the personal is political.’³⁰ The corollary of this is commitment to peace and justice, inclusivity, integration and holism.

Divine women: Goddess and Wicca

Carol Christ (1987) presented a specifically woman-centred view of the divine in the figure of the Goddesses. In pre-patriarchal³¹ times the Goddess was venerated for her interconnection between earth and human bodily sexual energies (Spretnak 1991). It is considered that women were esteemed for the same reasons they were despised in patriarchal religions: because they literally gave birth to physical life as well as nurturing new humans. These were aspects of life that women regarded as ‘sacred,’ as was life in all its forms. The Goddess was said to be distinct from the patriarchal, patrilineal warring tribes of Indo-European civilisations who worshipped the transcendent sky God, where, as Neumaier-Dargyay (1995) wrote

God the father is positioned in heaven in world-negating intangibility; the Goddess is seen as immanent in this world, the earth. She is immanent, tangible; open to human experience [...] “god” can be understood as an abstract noun, and “goddess” as a verb. (p, 157)

She also represented cyclical changes related to her bodily functions of menstruation, pregnancy, birth, dying and death. She was said therefore to represent an earth-based spirituality, immanence and interconnectedness (Starhawk 1979 1989 1999). Moreover, the Goddess is regarded as a metaphor to describe feminine experience as “...a formative and sustaining power” (Neumaier-Dargyay 1995:157). In this, the Goddess is in contrast to the transcendent God of patriarchal religions and the wish on behalf of its followers to transcend the earth and the body (Christ 2002). Further, in contrast to the Ten Commandments of Judeo-Christianities believed to be revealed by a spiritual, transcendental God, the morality of the Goddess is rooted in this earthly life. These ethical principles or ‘touchstones’ are described by Carol Christ (1998):

³⁰ Betty Friedan (1964).

³¹ c 6500-3500BCE in Old European civilisations and up to 1450 BCE in Minoan Crete (Gimbuta 1989).

Nurture life;
walk in love and beauty;
trust the knowledge that comes through the body;
speak the truth about conflict, pain, and suffering;
take only what you need;
think about the consequences of your actions for seven generations;
approach the taking of life with great restraint;
practise great generosity;
repair the web. (p.252)

Although there is scholarly debate about the various claims of the Goddess movement (Rountree 2001) similar critiques are made of other representations of the past, as Rountree (2001) commented:

All representations of the past have a bias and - feminist archaeologists have shown - traditional interpretations frequently demonstrated an androcentric bias. (p.22)

Spretnak (1995) pointed out that although Goddesses had been holy women, in Judeo-Christianities they were presented as 'temple prostitutes' of the 'cult of Artemis,' rather than 'sanctified women' of the 'religion of Artemis,' whilst one does not read of 'the cult of Jesus' but the 'religion of Jesus' (p.6). Although Mary is a remnant of goddesses in Christian traditions, she is venerated for being the mother of a son who was later claimed to be divine. Unlike Goddesses, Mary was not venerated for her own knowledge of herself. This demonstrates vividly how the dominant masculine religious views subordinated the feminine. The transcendental, spiritual, male God was a late addition to the pantheon which was to overturn the older goddesses and with it, woman and the body. Writing as a post-Christian, Spretnak (1995) says of the later dominant male religion:

It has a lot of blood on its hands; misogyny has always been inherent in Judeo-Christian core symbols and doctrines. The new patriarchal religion co-opted the older mythic symbols and inverted their meaning: The female Eve was now weak-willed and treacherous; the sacred bough was

now forbidden, and the serpent³², symbol of regeneration and renewal with its shedding skins, was now the embodiment of evil. The Goddess religion and its “Pagan” worshippers were brutally destroyed in the biblical lands. (p.473)

Similar to Goddesses in their practices were mediaeval wise-women, or witches. Wicca or witchcraft movements are contrasted with so-called evil witches or Satanism (Woodward 1996). However, because they wove spells to defy the power of the Christian church and its teachings, witches were said to be in league with the magical powers of the devil, or Satan (Chicago 1979). Witchcraft is said to be the only Western religion in which women are considered divine in themselves: “In a practical sense they have turned religion into psychology.” (Goldenberg 1994:213) This partially explains the mediaeval witch hunts by the Christian Church over many centuries in Europe and America: it was in the church’s power to persecute those who usurped its authority. Estimates of the number of women burnt as witches on the authority of Pope Innocent VIII vary from 30,000 to 9 million or more (Daly 1979: 183). Their self-knowledge, their powers in bodily healing rituals, such as brewing herbal concoctions or acting as midwives, meant they were blamed for the high incidence of deaths of mothers and babies, since only the transcendental, spiritual, male God of the Church was allowed to heal.

Whole body healing

Many Goddess’s and witch’s rituals were related to healing, including therapeutic touch, laying on of hands, caring and nurturing. These healing rituals were not

³² In both Mesopotamian and Canaanite myths, which are incorporated into Genesis accounts, the snake was connected with the goddess in a number of ways. One of these was as a sexual symbol and the goddess was intimately connected with sexuality and fertility. Often the snake in the myth is pictured with the goddess who is frequently beside a fruit-bearing tree. The tree is also symbolic as in Genesis it becomes the source of knowledge of good or evil (2:9, 2:17) or life (2:9, 3:22). This part of the Genesis narrative is believed by textual scholars to have been added by the Yahwist or someone else to forbid using the goddess to gain wisdom or knowledge. This is only to be gained from the male transcendental YHWH or God. Indeed, the whole of the account of the fall in Genesis 3 is arguably a “polemic against the worship of the snake” or serpent (Gardner 1973).

separated from material life, as spiritual practices became in the history of Christianities, for as Glendinning (1981) argued

Healing was, in effect a spiritual healing experience in which energy was released from the unconscious to become accessible to external reality. The power [...] lay in its ascription of healing to the life energy and its ability to awaken one's unique connection to that energy. (p282)

And

[...] feminist healers view the process of healing as involving the finer functions of the mind. To them psychic healing, energy transmissions, improvement by botanicals "faith" or visualisations are natural functions of life, not unfathomable, and therefore fearful mysteries. (p285)

Women's association with nature, however, as described above, particularly through childbirth and child rearing, and nurturing, has arguably been to their detriment, since by identification with nature this has made them socially inferior to men, who have consequently subordinated and oppressed them (Firestone 1979). Therefore, the argument continues, having an essential nature that is woman's is contrary to the best interests of women, and others.

The opposite argument, however, is that such identification gives women superior knowledge of the world. (Daly 1983, Rich 1976) Women, it is argued, learn two kinds of knowledge in childhood: one about their bodies from their mothers (Chodorow 1978)³³ and the second about the outside world of culture from their fathers. Since women are closer to nature they are less likely to engage in pursuits that destroy it. This is the root of the eco-feminist movement where woman is identified with her biological body as the "taproot" that links her with mother earth, or nature (Trask 1986:94).

Such feminists argued that there was an essential difference between women and men, based on reproductive and nurturing functions, and that these functions made women superior to men. Hekman (1990:136) argued that the view that there is a universalistic woman's nature is so deeply entrenched in contemporary cultural psyches is that this influences even feminists. This raises questions about the

essentialist nature of women /men which I discuss below in this and the following chapter.

The point of my discussion of Goddess and Wiccan discourses, however, is to demonstrate the hiddenness and suppression of them and their healing knowledges of the body by patriarchal religions, rather than to elevate them as models for nurses in the twenty-first century. Nevertheless, why should they not be available for women, and others, to choose, with the emphasis on the body and its interconnection with the earth and life, instead of the dominant patriarchal religious constructions of the world as matter, subordinated to spirit as God above?

On the other hand, it has been argued that the whole person - body, mind/and spirit, not just the spirit can find self-fulfilment as the self is open to the healing, non-abusive, transformative power of the divine (Coakley 1996). Spalding (1999) raised another problem, arguing that spiritual feminism can be unrealistic about the reality of women's daily material lives since women can be as negative to and about each other as men have been said to be in the accounts I have explored in this chapter. She believed that having a God transcendental to earthly life can be more empowering than the position that bodiliness is all there is. If the latter is the case, she asked how women could be empowered to resist oppression and injustice by other women. However, from my own experience I am not sure how belief in a transcendental God can do so either. Equally, I am inclined to agree with Spalding that spiritualising life, whether from feminist or masculinist perspectives, may not be the solution in practice to "...affirm human, and especially women's bodiliness and which can visibly challenge continuing dualistic norms." (p.85)

To sum up, we have seen so far in this brief historical overview of feminist informed theologies that some have argued that the spirit is perceived as masculine and both separate and superior to the body and woman which had been venerated in pre-patriarchal times. However, does a construction of divinity as female or woman improve matters? I move now to discuss contemporary post-modern feminist critiques of hierarchical binaries.

Beyond binaries

When considering gendered caring, we have seen that masculine/feminine and male/female are both culturally constituted binaries which maintain the dominant heterosexual requirement in patriarchal cultures. Post-feminist, post-structuralist discourses challenge oppositional binaries by seeking to destabilise the notion of any unified subject, gendered or not. This move includes decentering universalistic theories of any sort, including therefore the idea of a God and a truth for all people, for all time, which religious fundamentalists of all types tend to claim. Although this movement has been criticised for ignoring the concerns of women (Greer 1999), it has many attractive/positive features, such as its inclusive pluralism, its refusal to endorse the victim status of women qua women and its preference for women's empowerment. Furthermore, it stands on the shoulders of political and social endeavours of earlier feminisms and remains informed by gender critiques which attempt to deconstruct the essentialism of race class and gender. As we saw earlier in this chapter, this fixed opposition of male/female, men/women and the respective social roles are determined by biological difference. On the other hand, anti-essentialism also takes the stance that since it is patriarchy that has determined binaries and woman as 'other' than man, this is to be resisted.

Towards reintegration of dualisms: deconstructing gendered bodies

Feminist theorist Butler (1990) in *Gender Trouble* (GT) demonstrated that to portray the subject as unified and singular, as patriarchy does, is to misunderstand the social powers operating through limitation, prohibition and regulation which control subjectivity as masculine, trans-cultural and trans-historical. This construction renders woman as the 'Other', as "...a mysterious and unknowable lack, a sign of the forbidden and irrecoverable maternal body" (GT: 326). Butler called for a reintegration of the concepts which are often presented as dualistic splits of male/female, man/woman, and superior/inferior, domestic/public with their interconnected concealed exploitation of women and their work (p.328). She did this by challenging the notion of an essentially stable, cohesive, category of woman by dispensing with the idea that sex or gender is an 'abiding substance' (GT: 6) since,

...gender is not a noun [rather it is] performative, that is, constituting the identity it is purported to be. In this sense gender is always a doing, though not by a subject who might be said to pre-exist the deed. (GT: 25)

Here Butler drew attention to identity, as an inner, subjective ‘self’ or ‘essence’ as being in process, rather than a fixed or stable product. Indeed Butler perceived all gender positions as performance. In *Bodies That Matter (BTM)* Butler (1993) argued that considering gender as performance demoted the hierarchies of male/female since it allowed for movements between these hierarchical constructs. Queer theory,³⁴ in particular undermines and challenges this construction of biology and culture by emphasising diversity in biological sex and gender constructions. Partly as a result of these deconstructions of boundaries between biological sex and culturally determined roles or gender, gender and sex are debatable terms in modern feminisms (Butler 1990 1993).

French feminist theorist Cixous (1976) argued that our bodies are social constructions, inscribed in and through language. On this argument, there is essentially no natural woman, only a social construction dependent on language. In this way, our idea of ourselves is socially constructed and historically situated, rather than an historical and universal, as those who claim that there is a woman’s ‘nature’ must believe. As Simone de Beauvoir (1949) famously said, ‘woman is not born, rather she is made’, maintaining that, to argue for the essentially³⁵ feminine as did the ‘metaphysical feminists,’ rather than the constructivist feminist post-structuralist position, was to fall into the trap of perpetuating the differences that had historically rendered women inferior to men. As well as endeavouring to overcome difference between man/woman, this post-structuralist debate about gender engages with what might be thought of as the spirit or person and in particular how if at all this may be

³⁴ The aspect of Queer theory I adopt in my thesis is that of post-structuralist feminisms which challenges fixed gender/sex boundaries and stereotypes, man/woman to offer a more complex feminist and sexual politics. These recognise the interplay of cultural and social contexts in the formation of identities. (Gamble 1999).

³⁵ An essentialist view holds that there is a particular feminine essence, however recent scientific evidence argues that each human being has both feminine and masculine principles and the development of male or female genitalia in utero is dependent on hormones.

separable from the physical body and it is to this I now turn in my discussion as they are interrelated for my purposes here.

As we have seen in this chapter, with post-Christian feminist theologians Daly (1983) and Hampson (1990 1996) et al, constructions of spirituality outwith the body have been considered harmful to women and the body. This is of central importance in my study.

Here I depend on translations by scholars in the field. By focusing on the body and especially the woman's body, Irigaray urged us to overcome divisions between an inner 'self' or spirit and outer body and instead to reconceptualise ourselves through our bodies.

Irigaray posited that women cannot have anything in common with a male, phallic God. Since woman's bodily experience is different to man's, and that woman's sense of identity of herself is within herself. This led her to suggest that woman can mirror herself from the inside, to maximise her embodied consciousness (Irigaray *Speculum*, Trans. Whitford 1991). Since women's experience of herself is continuously fluid, as in experiences of menstruation, of the mucous membranes of 'two lips together' she is everywhere without boundaries. (Irigaray *The Sex Which is not One* Trans. Porter & Burke 1985) She intentionally confuses boundaries between previously distinct areas of human experiences, the real and the symbolic. A woman does not need to go outside her experience of herself; she is indefinitely other in herself, with no need of the transcendental male created by centuries of patriarchal discourse which values mind-spirit over body.

Irigaray extended her critique of masculine religion to its values which, as we saw in Plato, are inscribed in the whole of Western philosophy, as well as education, science and psychoanalysis. Grosz (1986), in discussing Irigaray (1993) *Divine Women*, clarified her argument that women need to reconstruct the symbolic frameworks that make masculine ideals the norm against which all humans are expected to measure themselves: "...we must not immobilise ourselves in these borrowed discourses..." (p.217) "...as we close our ears to what does not echo the already heard." (p213) For instance, as we saw earlier in the chapter, our ears have not heard the experience of women as Goddesses due to the silencing of this by dominant masculine discourses.

Consequently we only hear of the dying and rising male saviour of Christianities and we do not hear that, for millennia, women had been revered for their life-giving power in this life on earth. Rather, Irigaray (1993) in *Divine Women* that women need to have their own divine '*imaginaire*' 'to imagine the divine for themselves so that they can regain their own subjectivities and overcome the centuries of their suppression by men and masculine Gods. The language used by Irigaray is, however, tentative, fleeting and ephemeral, though this is said to be deliberate to subvert the dominant discourse of male centred rational discourse.

These important contributions to the debate about the categories woman/man self/spirit demonstrated the permeability of the socially constructed gender/sex boundaries in which the category 'woman' loses the sense of unity. On the other hand, the social construction of women too has its critics since it is arguably this position that has led to the oppression of women, especially sexually, the main tenet of feminism (Stacey 1986).

Furthermore, if identity is constructed solely by social forces, this can be deterministic since it leaves little room for individual agency. As MacInnes (1997) observed:

The self is something that can never be perfectly socialised, that in part lies beyond the public that in other words contains an 'unconscious'.
(p.148)

These considerations about the nature of woman and whether this is universal and essential for identity are important for the claims of feminism to represent women's experiences and knowledges as being different to men's. Furthermore, and of great relevance to this study, they are important in considering the claims of knowledge of spiritual experiences which both men and women claim and leads them to argue that nurses should give spiritual care to patients.

Summary

In conclusion, this chapter has presented nursing theories of spiritual care as either so necessary to patients that it supersedes aspects of bodily life, or that nursing itself is spiritual. Differing concepts of spirit, soul, psyche and dualisms of spirit/body

allegedly subjugated the body and woman. These were traced to patriarchal religions whilst feminist critiques presented various forms of earth-bound spiritualities related to feminine healing and nurturing. A way forward was represented by deconstruction of the binaries man/woman towards a more integrated sense of subjectivities as self-body. Self-contained subjectivity was said to preclude the need for a transcendental spirit or God. Feminist informed spiritualities and theologies raised important points about spirit/body constructions developed by men in patriarchal times, since these are said to have subjugated woman and the body, as well as the earth and 'others'. On the other hand, some explicated feminine images of the same spiritual God and argued these offer liberation of the body and the earth. These theories though complex and wide-ranging are necessary in investigating spiritual care by nurses, since nurses are mainly women and bodily care their main concern. These theoretical perspectives will inform the philosophical approaches and methods of my study which I describe in the following chapter.

CHAPTER TWO

A different standpoint

*In the Kuhnian sense, feminists introduce
a new paradigm for human understanding*
(Harding S. & Hintikka M. 1983: xiv)

As discussed in the previous chapter, feminist informed theologies challenge dualistic claims of transcendental, spiritual Truth, divided from material life, and argue that ‘truths’ about life are in and around bodily life. On this view, it is axiomatic that there is engagement with social, political and other material aspects of bodily life and unpardonable to separate them (see, for instance, Radford Ruether 1983, Althaus-Reid 2000, Tatman 2001).

Similar arguments are made by feminist epistemologists about modern epistemologies based on dualisms. Harding (1986) argued that Descartes, Locke, Hume and Kant, the fathers of modern empirical epistemologies, based

Their perceptions of the nature and activities of what they took to be the individual “disembodied”, but human mind, beholden to no social commitments but the willful search for clear and certain truth, remain the foundations from which the questions we recognise as epistemological arise. Once we stop thinking of Western epistemologies as a set of philosophical givens, we can begin to examine them instead as historical justificatory strategies - as culturally specific modes of constructing and exploiting cultural meanings in support of new kinds of knowledge claims. After all, the legitimacy of the theological justifications once presented for scientific (and mathematical) claims and practices was eventually undercut by the claims of modern science; the scientific claims and practices became more intuitively more acceptable than the theologies invoked to justify them. (p.141)

It is argued therefore that feminist epistemologies should undercut the authority of modern epistemologies because these ignore the importance of gender and implicitly use masculinist ways of knowledge creation. Feminist philosopher Langton (2000) described such epistemologies as

...merely a partial story of the world told by men. What women know about the world fails to enter this official story about life, the universe and everything and the incompleteness and partiality of this story goes unnoticed. (p. 133)

Among other criticisms, as Haraway (1989) also argued, women and their concerns are left out of the area deemed to be scientific³⁶ and of relevance to knowledge creation and claims to worthwhileness. Consequently, feminists argue that knowledge needs to include this kind of experience of society and the world (Hartsock 1983, Nicholson 1990). Although several feminist epistemologies have been developed since the 1980s, the one which is most suited to understanding why nurses have to give spiritual care in addition to bodily care is feminist standpoint epistemology. This incorporates critiques of the political, ethical and social effects of taken for granted androcentric power hierarchies and how these affect woman and the body, where body is taken to mean the whole of lived biological and social experience within the material world. Feminist standpoint epistemologies aim to both include women's social experiences as valid in their own terms and overcome dualisms. This chapter therefore discusses standpoint epistemologies and identifies some links with feminist inspired theologies discussed in the previous chapter, before moving on to discuss/outline/introduce the study design and methods.

Standpoint epistemologies

Historical basis

Standpoint epistemologies developed from the political philosophy of Marx, Engels and, later, Lukacs, itself derived from Hegel's master/slave critique. Hegel argued that the world would look very different from the perspective of the slave than the master. Marx and Engels developed this into the standpoint of the proletariat, in which human labour is a commodity exchange with more value than the subsistence wages paid by employers (McBride 1995). They argued that Western capitalist

³⁶For instance, the significant contribution of the talented scientist Rosalind Franklin to the development of the discovery of DNA was left out of *The Double Helix* (1968), the book which described how DNA was discovered by Nobel prize-winners Watson and Crick in 1962.

society is stratified by social class to the benefit of masters (capitalists/oppressors) at the expense of workers (proletariat/oppressed) whose invaluable contributions to society are marginalised and invisible. Importantly, the separation of mental from manual labour in capitalist production resulted in abstractions and mystifications in scientific knowledge.

This epistemic stance demonstrated the limitations of social knowledge created by dominant groups which further legitimated exploitation. The activities of those at the top of any society stratified by class, gender, race or other political category will determine what those at the bottom of such societies will understand about themselves and their worlds. In contrast, the knowledge gleaned from those at the bottom of the social hierarchy can give knowledge that is helpful for more humane relations. This is because the experience and lives of marginalised peoples, as they understand them, provide particularly significant problems to be explained for research agendas. According to Harding (1993)

These experiences and lives have been ignored as a source of objectivity-maximizing questions, the answers to which are not necessarily to be found in those experiences or lives but elsewhere in the beliefs and activities of people at the centre who make policies and engage in social practices that shape marginal lives [...]. Furthermore, these invisible activities are made visible. Those in dominant positions in society limit knowledge as they are unaware of the questions necessary to ask about received belief. (pp. 54-55)

For standpoint epistemologists, then, knowledge emerges when the marginalised oppressed struggle against the oppressors so that their standpoint is visible as valuable and legitimate knowledge. However the effect of the labour of caring assigned to women was not included in Marx's critique, hence the need to develop a feminist epistemological standpoint.

Developing a specifically feminist epistemological standpoint

The Marxist analysis of society was transposed onto gender relations by several feminist theorists in the 1970s. Although there are other standpoint theorists I shall

focus my discussion around the work of Nancy Hartsock (1983) *The Feminist Standpoint: Developing The Ground for a Specifically Feminist Historical Materialism* (FS); and Hartsock (1989) *Revisiting Standpoint Epistemology*; Donna Haraway (1988) *Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective* (SK); and Sandra Harding (1986) *The Science Question in Feminism and Rethinking Standpoint Epistemology: What is 'Strong Objectivity?'* (SQ) (1993).³⁷ According to these theorists, feminist standpoint knowledge is required to expose how patriarchy has pervaded our concept of knowledge and to correct the gendered social relations which have developed in consequence (FS p.284). Much of the work of these theorists is regarded as an extended conversation with each other.

Feminist empiricism

Harding (1986) described how feminist standpoint epistemologies developed from feminist empiricism which, in turn, incorporated many of the agendas of the women's movement to "...resist dividing mental, manual and caring activity among different classes of persons." (SQ p. 144) It was recognised that rather than dividing human endeavours into intellectual and emotional domains these should be reunited into a "...harmony of holism and complexity," as a non-reductionist way of knowing (SQ p.144). This, it was argued, would minimise "subjugated knowledges" as Foucault termed it. However a more androgynous approach to knowledge did not address the specific issues of women's experiences. The specific aspect of social life that had been left out of the Marxist analysis and which was challenged by feminist empirical epistemologies was the effect of caring being assigned exclusively to women (SQ). It was therefore identified that

Feminists must explain the relationship between women's unpaid work and paid labour to show that women's caring skills have a social genesis, and not a natural one. (SQ p.143)

³⁷ To make reading easier I use abbreviations (FS) (SK) and (SQ) respectively to denote which work I am referring to in my discussion here.

And it was argued that

Women's socially created conceptions of nature and social relations can produce new understandings that carry emancipatory possibilities for the species. (*SQ* p. 145)

These were to be found in

...the conceptions of the knower, the processes of knowing and the world to be known...[...] to be justified in terms of women's different activities and social experiences created in the gendered division of labour/activity. (*SQ* p. 146)

According to Harding (1986) the place to start is

...the lived realities of women's lives where we can identify the grounding for a theory of knowledge that should be the successor to both Enlightenment and Marxist epistemologies. (*SQ* p.146)

This new feminist standpoint epistemology will, according to Harding, overcome the identified dualisms which created divisions between manual and intellectual labour. To feminist historian of science Nancy Hartsock (1983), the dominant worldview is presented as the truth, when, she argued, it is demonstrably false, dangerously incomplete, 'partial and perverse' (*FS* p.285). In Hartsock's words

...the feminist standpoint allows us to understand patriarchal institutions and ideologies as perverse inversions of more humane relations. (*FS*. p. 284)

In other words, if human activity is structured in opposing ways then the vision of each will present an inversion of the other in systems of domination where the vision of the dominant group will be partial and perverse. Here Hartsock subsumes women' for Marx's 'proletariat.' (*FS* p.289) and maintains that the sexual division of labour required to maintain capitalist society renders women an oppressed group, where women as a social group have lives that are said to be different to men's. Men (read

capitalists/oppressors) exchange their work as commodities but women (read workers/oppressed) have no exchange value for their work. She takes as axiomatic of women's experiences that the realities of life for both 'oppressors' and 'oppressed' are real or 'true' enough for each group. It is seen 'natural,' therefore, for this social order to persist, as discussed in the previous chapter, so that a woman cleans, cooks, and cares for bodily and relational needs of children, men and others so that they can attain 'higher' mind-spirit pursuits. Hartsock (1983) described it as "extracted from [women] by men primarily in the home but also in the workplace" (p.283) and, in consequence

There are some perspectives on society from which, however well intentioned one may be, the real relations of humans with each other and the natural world are not visible. (p.159)

Importantly, Hartsock argued that women's labour was different to proletarian labour in that it was basically oppositional to the mental/manual dualities of masculine thought and activity. Hartsock saw men's/proletarian labour as midway between masculine/bourgeoisie and women's labour as the latter is

...more fundamentally involved in the self-conscious, sensuous processing of our natural/social surroundings in daily life - the distinctively human activity. (p151)

Hartsock (1983) argued that by contributing to subsistence by feeding, clothing and providing homes to enable people to survive

The activities of woman in the home as well as the work she does for wages keep her continually in contact with a world of qualities and change. Her immersion in the world of use - in concrete, many-qualified, changing, material processes - is more complete than a [man's]. And if life itself consists of sensuous activity, the vantage point available to women on the basis of the contribution to subsistence represents intensification and deepening of the materialist world view and consciousness available to the producers of commodities and capitalism, an intensification of class-consciousness. (p292)

It is in investigating the nature of women's activities in child-care that the inadequacy of the Marxist account is revealed. According to Hartsock (1983) the fundamental aspects of child care are assigned to women:

Women also produce/reproduce men (and other women) on both a daily and long-term basis. This aspect of women's 'production' exposes the deep inadequacies of the concept of production as a description of women's activity. One does not (cannot) produce another human being in the same way one produces an object such as a chair....Helping another to develop, the gradual relinquishing of control, the experience of the human limits of one's action. The female experience in reproduction represents a unity with nature which goes beyond the proletarian experience of interchange with nature. (p.293)

I quote these accounts at length since they detail those aspects of caring which, as discussed in the previous chapter, are seen to be feminine or women's roles, are also those of nurses/nursing and which "remain part of the world created by masculine domination." (Harding 1986:150)

From this epistemic perspective it was argued that women's experience should be the "grounds" (Smith 1990) of feminist standpoint knowledge and that such knowledge should change disciplinary knowledges. The critical edge of feminist theology was seen to be "the full humanity of women which has not existed in history"³⁸ (Ruether 1983:18). and, in nursing, the small but growing number of studies of nurses and nursing care which identified gender as a cause of continuing oppression of nurses and nursing (see, for instance, Lawler 1991, Smith 1992, Davies 1995). In my study into nurses giving spiritual care, these insights into knowledge creation are valuable.

Ethical/political stance of feminist standpoint epistemology

Already, as described above, it can be seen that politics are central to feminist standpoint epistemology. In Harding's words,

³⁸ However in line with post-structuralist approaches, which I discussed at the end of Chapter One, Ruether sees woman as in process, along with all human beings, rather than as a fixed static category 'woman'.

standpoint epistemology sets the relationship between knowledge and politics at the centre of its account in the sense that it attempts to provide causal accounts - to explain - the effects that different kinds of politics have on the production of knowledge [...] It sets out a rigorous “logic of discovery” intended to maximise the objectivity of the results of research and thereby to produce knowledge that can be for marginalised people (and those who would know what the marginalised can know) rather than for the use of dominant groups in their projects of administering and managing the lives of marginalised people. (Pp.55-56)

This involves ethical judgements about what is best, good or right, and their negative corollaries. Hartsock posited *a priori* value judgements that women are oppressed as a social group within patriarchal societies. She valued humane relational cooperation and connectedness and argued that reality to be known is located in this material bodily life and relationships. This epistemic position contrasts with abstract masculinist epistemologies. The latter are deemed ‘perverse’ since they achieve the opposite of what is intended; that is, they bring death and destruction due to the domination of people and the world by a few powerful ‘knowers.’ (FS p.303) Specifically, what is not valued in feminist standpoint epistemology is knowledge that leads to disembodied domination of people and the earth, transcendence and being ‘born again’ (FS pp587, 589). The use of theological metaphors by the authors of feminist standpoint is illuminating. As Haraway (1988) expressed it

Feminists don’t need a doctrine of objectivity that promises transcendence, a story that loses track of its mediations just when someone might be held responsible for something [...] Immortality and omnipotence are not our goals. But we use some enforceable, reliable accounts of things not reducible to power moves. (SK pp579-580)

The perversity of supernatural/natural worlds

Hartsock (1983) argued that the masculine world to be known is in fact two worlds. As we have already seen in the previous chapter, these two worlds are the transcendental and abstract, attainable only by the detachment of the spirit-mind from the body; and the material or bodily world, which, in turn, is demeaned in the process of attaining the allegedly better ‘other’ world. The result is that cosmology

and human nature are constructed as hierarchical dualisms of God/man, spirit-mind/body, culture/nature, abstract/real, male/female and separation of supernatural from natural (*FS* p. 290). From this perspective, knowledge of what it is to be human in the world entails oppositions between bodily life and allegedly abstracted spiritual life. Indeed to become really human, a person is believed to need to become disembodied. Hartsock argued this threatens one's very 'being' (*FS* p.296). From the epistemological stance of the feminist standpoint however, knowers and the world are different, since to be human in the world is to be embodied in the flesh. The use of "sexual division of labour" is a deliberate emphasis on life as bodily grounded. Related to this is the socio-cultural context of life as relational (*FS* p.294). However, as discussed in the previous chapter, these aspects of life are demeaned in Western capitalism since, informed by hierarchical dualistic knowledge, they are assigned to culturally constructed feminine bodily roles, chiefly those of women. In different ways, this negatively affects man, woman and society and, according to Hartsock, is a reversal of the proper valuation of human activity. Hartsock (1983) argued that

Men's power to structure social relations in their own image means that women too must participate in social relations which manifest and express abstract masculinity. The most important life events [the most abstract] have consistently been held by the powers that be to be unworthy of those who are fully human most centrally because of their close connection with necessity and life; other work (the rearing of children), housework, and until the rise of capitalism in the West, any work necessary to subsistence. In addition, these activities [the most concrete] in contemporary capitalism are all constructed in ways which systematically degrade and destroy the minds and bodies of those who perform them. (*FS* p. 302)

The important epistemological claim of feminist standpoint according to Hartsock is that persons are what they do and what they do determines how they understand themselves and their worlds which differ in significant ways. These everyday lived activities of material life, and critical reflection on them, provide the epistemology of feminist standpoint.

In my study, I follow Hartsock in making *a priori* value judgements from my own experience as a nurse, and knowledge as a nursing lecturer, that nurses and caring in

nursing are marginalised as feminine/women's activities in ways that historically masculine/men's activities are not, specifically medicine, theologies and religious spiritualities.

Reverting to essential woman/man?

A criticism of feminist standpoint epistemology is that it reverts to the essentialist position of woman and man (Tong 1995). As argued in the previous chapter, this was considered undesirable, particularly in post-structuralist thought. As feminist standpoint maintains that women see the world differently to men due to their sexed/gendered roles, this presupposes that this is true of women across all social classes, educational backgrounds, and ethnicities and so on. However, although women's lives are the grounds of a feminist standpoint epistemology, Hartsock did not understand her account to be definitive of all women or men (*FS* p.298). Harding (1993) also put it that

There is no single ideal woman's life from which standpoint theories recommend that thought start. Instead, one must turn to all of the lives that are marginalised in different ways by the operative systems of social stratification. (p60)

According to Harding (1993) there is at best ambivalence about the categories masculine/feminine, man/woman on the grounds that these have exalted man as human:

Research processes that problematise how gender practices shape behaviour and belief - that interrogate and criticize both masculinity and femininity - stand a better chance of avoiding such biasing gender loyalties. (p.60)

Harding (1993) specifically denied essential woman:

Feminist knowledge has started off from many different women's lives; there is no typical or essential woman's life from which feminisms start

their thought. Moreover, these different women's lives are in important respects opposed to each other [...] nevertheless, thought that starts off from each of these different kinds of lives can generate less partial and distorted accounts of nature and social life. (p.65)

Indeed Harding specifically pointed out that the ultimate goal of feminist research is to eliminate dominant interests even of minority groups such as feminisms in order to achieve the end of both femininity and masculinity.

Whilst criticising gender loyalties, feminist standpoint nevertheless argues that women's lives have been inappropriately devalued. Furthermore, in feminist standpoint, rather than individual women it is as a social group women are considered, and, moreover, historically situated. Therefore, feminist standpoint epistemology both speaks on behalf of the notion it criticizes, as well as tries to dismantle women or femininity. It is this contradictory nature of the enterprise of standpoint epistemology that brings many challenges and creativity. (p.74)

At times, this can lead to incoherent individual knowers and communities of knowers Harding (1993) contended that:

...the subject/agent of feminist knowledge is multiple, heterogeneous, and frequently contradictory in a second way that mirrors the situation for women as a class. (p.65)

Against this, it is argued that it is difficult to expect people deemed 'incoherent' to be accountable for their knowledge claims (Code 1995),

It is the thinker whose consciousness is bifurcated, the outsider within, the marginal person now located at the centre³⁹, the person who is committed to two agendas that are by their nature at least partially in conflict. – [...] It is starting off thought from a contradictory social position that generates feminist knowledges. So the logic of the directive to "start from women's lives" requires that one start one's thought from multiple lives that are in many ways in conflict with each other, each of which itself has multiple and contradictory commitments. This may appear an overwhelming requirement - or even an impossible one - because Western thought has required the fiction that we have and think from unitary and

³⁹ Here Harding refers to work by feminist theorists "who describe this kind of subject of knowledge" in Smith *Women's Perspective*; Collins *Black Feminist Thought* and bell hooks *Feminist Theory From Margin to Center* (Boston: South End Press 1983).

coherent lives. But the challenge of learning to think from the perspective of more than one life when these lives are in conflict with each other is familiar to anthropologists, historians, conflict negotiators, domestic workers, wives, mothers - indeed to most of us in many everyday contexts. (Pp.65-66)

From a nursing perspective, a nurse who has reached the pinnacle of the career ladder without breaks for childbirth and childrearing is in a similar social situation to any man. Equally, the nurse who is in management, education or research is not in the same social sphere as the nurse who has to juggle Harding's "contradictory commitments of at least two agendas" of runs to child-minders and after school activities, with working twelve-hour shifts starting at 0730, as well as distressing experiences of caring for the sick, dying and bereaved. And the same applies to whether it is a man or a woman who is the nurse, as it is nursing itself that is gendered, although, as we have seen in the previous chapter, it is mainly women who nurse. I am not investigating why women are caring vis-à-vis men, I am interested in knowing why nurses as a socially gendered group are asked to give spiritual care in addition to bodily care, since this implies the possibility at least that there is something lacking in bodily nursing care. Furthermore, constructions of spirit/ body have been demonstrated to have negative effects on the body, and, by association, on women. Indeed, as we saw in the previous chapter, the spiritual is ontologically reified as supremely valuable over against bodily life.

The politics of knowledge

Just as feminist deconstruction of spirituality had the twin effect of clarifying the gendered power dynamics involved and exposing patriarchal constructions (Jantzen 1995:13-17), feminist deconstructions of knowledge production have shown the various ways knowledge and power have oppressed women and the body⁴⁰. This approach, therefore, is identified by a concern to interrelate injustice with political action for women or/and their traditional concerns and hence links with those

⁴⁰ From the earlier feminist movements for the *Vindication of the Rights of Women* (Wollstonecraft 1929), and for suffrage (Pankhurst 1924), the emancipation of women from inferior, subordinate positions in society has been the centre of feminist knowledge.

feminist theologians and others who argue for more humane relations and life conditions for all.

Construction of feminist knowledge, from the start, moved easily between personal lives and political activism and was related to women's subordinate position in society to investigate why this unequal state of affairs is perpetuated in institutions, such as marriage and the church, as well as health care. Since most nurses are women, and nursing is predominantly women's work, traditionally prescribed by male, medical professionals (Cash 1997, Davies 1995) and spirituality is also traditionally constructed by male theologians, I chose to use feminist methodologies to contribute to my understanding of why nurses should be asked to give spiritual care to patients.

In sum, knowledge has been seen as partial and perverse since it has been masculinist. Arguably, this was due to the socially gendered sexist division of labour. Based on Marxist materialist philosophies, feminist standpoint epistemology seeks to develop a different standpoint of what is deemed valuable and valid in knowledge creation. This epistemological standpoint relates well to feminist informed theologies as liberation from oppressive masculinist ideologies, specifically, masculinist constructions of the world and humans into hierarchies of God/man, heaven/earth, spirit/body and man/woman. How, then, is knowledge created that includes marginalised or hidden experiences?

Creating knowledge

Everyday knowledge

The daily activities of lives are considered to be a good starting point for asking critical questions about why women do the work they do and, equally importantly, why this is valued less than work traditionally done by men. It is "feet on the ground"⁴¹ engagement with the context of life. For example, Smith (1987) pointed out that if we ask such questions, we will see that women are given work that men do not wish

⁴¹ I owe this term to a supervision meeting with Marcella Althaus-Reid, New College, University of Edinburgh, November 2003.

to do, particularly the mundane facts of messy care and feeding of bodies, from giving birth to death, caring for the bodies of babies, children, the sick and elderly, as well as their own bodies, and that the place for this caring is their own homes and similar places, like hospitals. Such care becomes invisible, natural and altruistic behaviour for females in relation to men's or more abstract work. Asking questions about why this should be, Smith suggested, leads to less distorted and partial knowledge of the relation between bodily caring and emotional work being allotted to one social group and abstract 'head' work to another. Since the interest in my study is why nurses should be asked to give abstract spiritual care, historically a masculine creation, an exploration of experiences of giving bodily nursing care is particularly suitable.

However, Harding (1993) argued, the experiences of lives of the 'lived world' of marginalised people are not the *answers* but the *source* of important questions arising from inside or outside those lives: the answers are not to be found where the questions are asked (pp 56-63). Hence my questions of the 'lived world' of nursing will be with reference to the studies by Ross and Bradshaw discussed in the previous chapter in which bodily care is considered insufficient on the one hand or completely sufficient on the other. Thus my questions will raise important further questions requiring answers which, according to Harding, will need to be taken outside of the individual experiences. Theoretical constructions of these personal experiences are also therefore necessary if knowledge is to be relevant to needs and political goals of emancipation from subordination, and so theory for feminists is not

... an abstract intellectual activity divorced from women's lives, but seeks to explain the conditions under which those lives are lived. Developing this understanding has entailed looking at the material actualities of women's everyday experience. (Jackson and Jones 1998:1)

Community of knowers

Importantly, from an epistemic perspective, whilst each individual is a source of knowledge, he or she is also part of a community of knowers. As we have already seen in this chapter, the feminist standpoint is an engaged position within social

relations which involves collective understanding of women as a social group. As Harding (1993) argued, it is a central feature of feminist standpoint that

Communities and not primarily individuals produce knowledge. For one thing, what I believe that I thought through all by myself (in my mind), which I know, only gets transformed from my personal belief to knowledge when it is socially legitimated. Just as importantly, my society ends up assuming all the claims I make that neither I nor my society critically interrogates. (p.65)

The community that produces knowledge in my study is nursing. As already examined, nursing knowledge has been left out in two distinctively important ways. The first way is that nurses' own value in nursing activities is not recognised as knowledge, even by nurses (Lawler 1991 et al). Secondly, nurses, as women, are left out and repressed and subordinated in ways that men and their knowledge are not (Davies 1995 et al). This epistemic position of a communal creation of knowledge also means that, as a researcher, I am not a distant, detached observer but involved in the collective creation of communal knowledge (p.285). Harding (1987) wrote:

To achieve a feminist standpoint one must engage in the intellectual and political struggle necessary to see nature and social life from the point of view of that disdained activity which produces women's experiences instead of from the partial and perverse perspective available from the "ruling gender" experience of men. (p.183)

As such I am part of the social group, not looking in but working from below as part of the membership of the oppressed group and incorporating my own experience as a woman and a nurse My research project therefore is one of 'us' rather than 'me' and 'them.'

This process of investigating and interpreting individual experience and communal knowledge creation requires the methodology - the theory and analysis of how research does or should proceed (Harding 1987) - and methods used to be credible and worthwhile.

Issues of credibility, worthwhileness and adequacy

Criteria for evaluating the rigour of knowledge claims in feminist research, as in qualitative research, have traditionally involved debates about reliability and validity (Morse Swanson & Kuzel 2001). Some view these terms as too dominated by objectivist positivistic knowledge paradigms (Brink 1991) whilst others argue that newer terms and processes should be used in newer knowledge paradigms such as feminisms. Post-positivistic approaches are contrasted by recognising that it is not possible to capture reality perfectly (Guba & Lincoln 1994), which terms such as 'validity' and 'reliability' at least suggest.

As my study is qualitative, it lies within the interpretive tradition where it is recognised that knowledge is 'situated' in subjective humanistic meanings. In this approach, discussion of personal experiences and meanings is said to be more appropriate, credible and worthwhile.

Credibility, worthwhileness and adequacy

Credibility is said to be demonstrated when the accounts of study participants are 'believable' to other feminist researchers who similarly assess the effectiveness of the literature, processes of data collection and analysis, the 'comprehensibility' of descriptions and examples of study materials, the logic of arguments and complexity of analysis (Hall & Stevens 1991).

The term 'worthwhileness' (Hartsock 1989) or 'adequacy' is preferred to 'validity' (Alder et al 1983) and is used to assess whether and to what degree the emancipatory goals of the research have been achieved. In this the relevance and significance of the study must be made clear. Three main criteria of worthwhileness are offered by Lather (1986) as: whether the voices of participants are visible, whether the relationship between participants and researcher is made evident and whether the researcher's position is theorised.

These authors also comment that reflexivity is central to the adequacy of the research. However, they also point out that it is insufficient to have unfettered subjectivity and preconceptions merely verified by the study. To create worthwhile knowledge, contrary, negative and alternative explanations should be offered.

Throughout my study I incorporate these approaches, for instance by a multi-disciplinary conceptual analysis of spirit and caring in Chapter One and a multi-method approach to collection of study materials by interviews, narratives and reflexivity.

Here I discuss the claims to the worthwhileness of knowledge created using feminist standpoint epistemology as my methodology.

‘Situated’ knowledges: social interaction rather than the “God-trick”

To feminist standpoint epistemologists, knowledge creation is seen as socially and historically ‘situated’ (Haraway 1988) since, “All thought by humans starts off from socially determinate lives” (Harding 1993:57). They simply disagree that the science of Western thought is not shaped by history and location since any thought is of “*an age*” and “the lives from which thought has started are always present and visible in the results of that thought” (Harding 1993:63). Thus the scientific world view is in fact a view of the dominant groups in modern Western societies, principally abstract and masculinist, just as the androcentric world view was in Judeo-Christianities.

By contrast, knowledge “based on laws and causal explanations, objectivity and scientific method” (Hughes 1997:33) is believed to give legitimate knowledge of reality external to the social world of the autonomous, independent knower (Tanesini 1999). This has been termed the “God-trick” (Haraway 1988 1991) or the ‘non-situated distanced standpoint’ from ‘nowhere’ (Code 1993). Furthermore, as objectivity is said to prevent subjective involvement or ‘bias’ it objectifies people by not taking subjectivities into account (Code 1993). However, those who claim such an objective stance inevitably bring their own subjectivities to the research process. Moreover, the lack of trustworthiness of many of scientific claims to be detached and objective to the subjectivities of the researcher have been well documented (Harding 1986 1993:63). Therefore, no researcher can be detached from the subject or subjectivities of scrutiny. On the other hand, it is said to be just as delusional to believe this is completely possible as it is for those who claim neutrality and detachment in knowledge claims (Harding 1993:57).

Feminist knowledge differs from non-feminist knowledge

Whilst the socially engaged approach to knowledge creation is common to other qualitative methods (Reissman 1993 Strauss & Corbin 1990) where, it is argued, knowledge is created through complex processes of social interaction between interviewer and participant (Silverman 1997), feminist standpoint epistemology claims that the everyday life of men and women is different in significant ways. Feminist researchers claim that ‘reason’, ‘reality’ and the ‘knowing self’ are themselves social constructions and therefore what Haraway (1991) described as the ‘privilege of partial perspective’ of ‘situated knowledges’. The problem in the late twentieth century to Haraway (1991) was not what reality is but what counts as knowledge. Since the 1980s feminist scholars in the West have been transforming hitherto masculinist paradigms of knowledge to include those of women. How, by and for whom knowledge is constructed and the role of gender within this process is consequently of central concern in feminism knowledge. Thus, Ramazanoglu & Holland (2002) defined feminist methodology as:

...shaped by feminist theory, politics and ethics and grounded in women’s experience. Feminists draw on different epistemologies, but take politics and epistemology to be inseparable. (p.171)

Nevertheless, standpoint feminists do not claim that knowledge is or should be value-neutral. Whilst standpoint epistemology argues against universalism and assumed objectivity it nevertheless advocates that, as Harding put it, “...some social situations are better than others as places from which to start off knowledge projects.” (p.61) Knowledge of women’s lives that demonstrates their subjugation and silencing in gendered society and which affects their well-being is worthwhile to women, men and society. For instance, feminist informed theologian Marcella Althaus-Reid (2000) argued that it was necessary to “reflect on economic and theological oppression with passion and imprudence” (p.2) in making visible the hidden, underlying structures that are repressive of marginalised, poor women. As the root cause of underlying layers of multiple oppression facing women, she challenges feminist methodology to ask question of women’s silence as a hermeneutical challenge.

To sum up, standpoint theorists argue that knowledge derived as disembodied, universal, invisible, trans-historical, dividing subject/object, consistent and coherent and depicting a unified, unitary subject is “Distinctively androcentric or Eurocentric.” (Harding 1993:71) By contrast, they argue first that knowers and knowledge are embodied and visible and ‘situated,’ located in historical time and space; second, subjects are not different, but on the same plane as objects of knowledge, hence subjectivity is “strong objectivity” in social sciences (Harding 1993:69); third, communities, not individuals, create knowledge and fourth, subjects/agents of knowledge are heterogeneous and contradictory.

I argue that we need to ask about experiences of nursing to see why spiritual care should be expected of nurses. However, at the same time, the nurses’ experiences in my study will not be my subjective experiences and may well be oppositional to mine, particularly in experiences and beliefs about potentially sensitive issues such as spiritual beliefs and aspects of care. However, this epistemic position advocates that “strong objectivity” is achieved in research by “strong reflexivity” (Harding 1993: 69) so that every aspect that has shaped my research study is made explicit. Reflexivity throughout the whole research process of collection, interpretation and understanding of research materials in knowledge creation demonstrates worthwhileness and credibility of knowledge creation. Therefore, before I describe the study methods I first describe reflexivity and my situatedness in the study.

Reflecting on my role in the thesis and issues of bias

Reflexivity

Reflexivity means making explicit the lived experience of the research encounter and process (Oakley 1981) and understanding how I am involved in creating, interpreting and theorizing the study materials (Kleinman & Copp 1993). This also affects how I relate to my study participants since as a researcher I am inextricably interrelated with the study participants in creating knowledge (Harding 1997, Kleinman & Copp 1993). Indeed reflexivity is considered by many feminist researchers to be a main theme in their research since it is said, amongst other things, to minimise power

hierarchies between researcher and researched (De Vault 1990, Olesen 1994, Harding 1997). Ramazanoglu and Holland (2002) asserted:

Taking reflexivity personally means reflecting critically on the consequences of your presence in the research process. (p.158)

Reflecting on my values and involvement as a researcher was important (Webb 1993). Hall & Stevens (1991) argued that researchers need to demonstrate they have considered

Their own values, assumptions, characteristics and motivations to see how they affect theoretic (sic) framework, review of the literature, design, tool construction, data collection, sampling, and interpretation of findings. (p.17)

For this reason, I here discuss those aspects of my being as a researcher, which could be called bias in overtly objective forms of research, but which are, inevitably, part of the whole research process, whether acknowledged or not.

I took my personal background and teaching role seriously when considering my approach with research participants. Although I did not overtly let my own beliefs or non-beliefs intrude, there were times when it seemed natural and right to say something of my own world and professional experiences.

Nevertheless, I recognised that my childhood background as a nominal Roman Catholic, exposure to widely differing cultures and belonging to two very different Protestant traditions at different stages in adulthood all enabled me to be both an 'insider' and 'outsider'. However, even when personally practising a religion, in more than thirty years of nursing in differing contexts I had never experienced a need for nurses to be directly involved in giving spiritual care, other than facilitating the role of cultural/religious practices.

Although open-minded, I inevitably brought my varied experiences to the study: my scepticism about the existence of spirit and spiritual care and my personal and professional experiences of the often subtle, hidden power of individuals and institutions to impose their beliefs onto others. It appeared to me, though, most

people in my study assumed that as I was teaching⁴² and researching spiritual care by nurses, I believed that nurses should give spiritual care to patients. This may have had an effect on their responses but my experience of teaching was that students were very well able to say what they personally believed, even when this was quite different to what I was teaching. As Isla said at the beginning of her interview: *I think 'oh my god this poor woman wants me to tell her about this [spiritual care] and I'm going to totally destroy it.'* Jennifer remembered I had *seemed to be a humanist in classes?* but went on to describe her own beliefs related to Eastern philosophies. In addition, as humanists as well as agnostics and atheists are said to have spiritual need (Burnard 1988a), the awareness of my humanist leanings need not necessarily have biased this participant's responses.

Many of the points already discussed above under methodology apply equally to the credibility and worthwhileness of my methods since methodology and methods are said to interrelate, as Wolcott (2000) stated: "Qualitative inquiry is more than method and method is more than fieldwork" (p.93). It is recognised in qualitative methods there would be some inconsistencies in both approach and content in my interviews because of the heterogeneous nature of the inter-subjective construction of knowledge. Consequently, I was not anticipating finding an exact 'answer' to my question but rather understanding, which is an inexact science

Conversational interviews

In contrast to the objectifying approaches of collecting what is claimed to be objective, factual information, conversational interviews enable knowledge construction that is said to be socially rooted. As discussed earlier in the chapter, knowledge is said to be co-crafted between the researcher and the study participants, each of whom may have differing perceptions of social realities. As Mischler (1979) argued, meaning must be viewed in its social context. It is recognised that in-depth interviewing captures the construction of meanings by individuals, where these may

⁴² For instance three students had been on a module in which I taught spiritual aspects of healing.

be plural, consensual or contradictory as I anticipated would be the case in investigating spiritual care by nurses. Mischler (1986) observed:

We are more likely to find stories reported in studies using relatively unstructured interviews where respondents are invited to speak in their own voices, allowed to control the introduction and flow of topics, and encouraged to extend their responses. (p.69)

Silverman (2000) however criticised unstructured interviews because they merely gave points of view or anecdotes of experiences. However, I believed the wide experiences of my study participants would enable the construction of worthwhile knowledge based in my methodology which recognised the subjective nature of all knowledge. I did not expect to find any knowledge separated from the human beings concerned in its creation.

Narratives or stories

According to Potter & Wetherall (1987), narratives are increasingly useful in research that has moved away from the idea of a single reality or truth to more overtly subjective interpretive approaches, as exemplified in positivist, empirical research. Frank (2000) preferred the term 'stories' to narratives since people do not tell narratives but stories

Stories or narratives are said to be the human way of thinking, speaking and talking about key life events and experiences (Bruner 1987, Atkinson 1998 Josselson & Lieblich 1995). Fairbairn and Carson (2002) maintained that all research is concerned with telling stories about ourselves and the world.

The narrative approach to interviewing takes as its fundamental problem the ways that meaning is expressed through discourse. Furthermore, narratives give voice to wider, diverse and more ambiguous perspectives, which are locally or culturally situated. Mattingley (1998) described stories as an excellent research method for considering the interplay of content, context and experience the clinical world. The teller of the story incorporates context, or details, surrounding the events being

described (Reissman 1993). Indeed it is argued that the story method is the most appropriate method for investigating complex human relationships (Bruner 1986, Mishler 1986, Koch 1998, Riessman 1993) where “the method the problem and the theory are intimately meshed together.”(Plummer 1983:122)

Increasingly nursing research is recognising the value of stories since the area of human life and death with which nurses are involved is frequently related by telling stories to each other. Gorman (1993) wrote that stories in nursing “...reflect the highly emotional, intensely personal, often brutal ...everyday life as lived by clients and witnessed by nurses.” (p. 1183) Fairbairn and Carson (2002) described narratives as giving:

...more accurate and more helpful stories of how the world of nursing works [...] because this experience of day-to-day practice is a valuable resource that needs to be recognised. (p.8)

Cody and Squire (1998) used the narrative approach in their research into the perceptions nurses had of good nursing care.

As stories are said to be valuable in creating worthwhile knowledge of the complex human situations in which I am interested, the knowledge constructed can be said to be as worthwhile and credible as that created by other methods, indeed even more so, since it is said to be “interpretative science in search of meaning, not an experimental science in search of laws.” (Goertze 1973: 5)

Information about study participants

Eighteen study participants were recruited between October 2002 and November 2003. The sole criterion for inclusion was experience as a nurse, irrespective of gender. Volunteers came from nurses studying part-time for further qualifications and who were taking modules in ethics and spiritual healing/complementary therapies. None came from more medically oriented modules ($n=180$). Information about the purpose of the study was communicated verbally and by letter (see Appendices).

Initially, I intended interviewing only nurses in Adult General Nursing. However, due to poor response rates to requests for volunteers, I accepted participants from a wide range of specialties.⁴³ All except one were Registered Nurses (RN) and were highly experienced. All participants were working as nurses and living in the central belt of Scotland at the time of their interviews.

Although unplanned, all but two of the nurses were women of white, Scottish ethnicity. Participants could therefore be expected to demonstrate the influence of the dominant Scottish/Presbyterian Christian culture. Indeed, it was striking that no participant had belonged to any other religious/cultural group. However, other religious communities in Scotland are admittedly small in size/so this reflects the general make-up of religious affiliation in Scotland.⁴⁴

Ages of participants ranged from mid-twenties to late fifties.⁴⁵

Conversing and constructing the research materials

Preliminary conversations: a focus group

Due to lack of response from the intended interviewee cohort, my initial research design had to be changed from interviewing lecturers about why nurses should be taught to give spiritual care. As a consequence of this preliminary nil result to recruit study participants, I held a focus group with eight volunteer staff nurses.

The focus group was held in October 2001 after the end of a class on spiritual aspects of care. The intention was to explore the topics and methods I intended to use in my study. The purpose of a focus group is to generate data or information (Barbour & Kitzinger 1999) and is said to be valuable for exploring sensitive personal experiences and opinions (Kreuger & Morgan 1993).

After reassurances about group confidentiality and anonymity, I asked the group for their views and experiences of spiritual care in nursing. Their response could be broadly grouped into three main categories. These were broadly grouped around

⁴³For details of nursing qualifications and experience and religious affiliation please see Table in Appendix.

⁴⁴Lothian Health Intelligence Unit Census (2002) included religious affiliation and showed the percentage of people in Lothian of minority ethnic origin as 2.8%. 39.6% were Church of Scotland; 11.57% Roman Catholic and those who said 'None' 34.4%.

⁴⁵For more information on participants please see Table in Appendix.

nurses' experiences of spiritual concerns as only relevant at the beginning or end of life; whether spiritual care apart from religious/cultural care was a nurse's concern and spiritual care as ethical practices. Notes were taken and word-processed after the meeting.

This preliminary process of collecting material gave me a guide to overall topics of likely concern to nurses; the complexity and integrated nature of the issues involved in researching spiritual care and the likelihood of sensitive and painful issues arising. Finally, the focus group discussion confirmed my intention to incorporate narratives in conversational interview methods since almost all group members talked of spiritual concerns in the context of stories of nursing patients and of their own personal experiences.

One-to-one interviews

One-to-one interviews were held between November 2002 and November 2003. Apart from one interview held at the place of employment, all were held in the University campus in which I was teaching and participants were studying. The ambience of Complementary Therapies classrooms was conducive to conversational interviews. This hopefully helped to make both the volunteer and me more relaxed. As Melia (1981) commented:

when data are obtained by means of an informal conversational style interview the researcher's approach and setting up of the situation is as important as, and indeed one could argue more important than the questions asked. (p.86)

After thanking the person for coming, and making pertinent individual comments related to travel distances, study schedules or the weather, I usually started off the interview by asking what nursing experience they had, which speciality and so on, with the intention of making them feel at ease with familiar material and to hearing their voice. I explained that I was interested in the nurse's own experiences of giving nursing care and that there were no right or wrong, or good or bad, answers.

I reminded them of the topic of my study and asked if giving spiritual care was new to them. Some nurses had given the matter some thought before the interview and started off the conversation themselves. Others however were a little quiet or nervous and in these cases I started to talk first. I tried to be as chatty and informal as is consistent with a professional approach to the research process. This was very important in establishing rapport for discussing potentially sensitive and even controversial issues (Renzetti 1993).

Once the mini-disc recording had started, I then repeated my introductory remarks about my interest in their experience of nursing care roles. This 'settling in tactic' meant that usually my voice was recorded first and we tended to forget about the machinery. It became a fine balancing act of relaxed conversation on the one hand and concentration of purpose on the other, as being a researcher was as new to me as being a researchee was to participants.

Although I was happy for participants to talk freely - and some did - most people preferred me to have some loosely framed questions as pointers to direct our conversation. This approach to the interview was largely successful in setting an informal air, though one or two participants continued to be anxious throughout the interview hour, and I needed to reassure them frequently that what they were saying and how they were speaking were fine. Regardless of how much I tried to be 'one of them' in my relaxed interview approaches, there seemed to be a keenness to please: I was undoubtedly a lecturer and a researcher. Unfortunately, the academic research process is inevitably loaded in favour of the power of the researcher over the researchee (Oakley 1981, Edwards & Ribbons 1998). I tried to ensure an equal balance between me and the interviewee as possible whilst recognising, as Mauthner & Doucet (1998) stated:

we must recognise the impossibility of creating a research process in which the contradictions in power [...] are eliminated. (p.138)

It seemed reasonable that study participants expected me to both lead the interview and to have knowledge about the topics under scrutiny. Equally, I frequently

reciprocated by asking participants about a particular treatment. Nevertheless, comments such as “I hope this is useful?” or “Is this what you want?” were not infrequent, perhaps indicating the anxiety of both myself and the interviewees. I repeated or enlarged on what I had said at the outset, that there were no right or wrong answers, and I was interested in their experiences so, of course, what was being said was absolutely what I wanted and was very interesting. Meadows and Morse (2001) noted that

High quality interviews are obtained from “good” participant (i.e. those who have experience of the topic, are articulate, and willing to report that experience and reflect on it) and analytically driven enquiry. (p.193)

As interviews progressed, and I settled with the research process and the recording mechanisms, I mostly dispensed with minimal note-taking and looking at my topic guide.

Indirect and contextual approach to knowledge creation

In keeping with my conversational approach to enquiry, I expected that nurses would talk about spiritual aspects by describing the context, or stories, of nursing care. Consequently, I did not use a direct approach to explore my stem research question: ‘Why are nurses being asked to give spiritual care to patients?’ Instead, I approached it indirectly, by getting nurses to talk about their nursing experiences. Swanson (2001) commented that this kind of indirect approach is common in a qualitative study:

“Why” questions are most often asked using an indirect approach in an attempt to elicit meaningful explanations and contextualisation. (p.247)

I felt that, in letting the nurses talk informally with me of their nursing experiences, the reasons why spiritual care is currently being asked of nurses would emerge.

Digression and developing discussions

I encouraged digressing and discussion of any point as interviewees wished, so the process of the interview became more of a discussion, though led by me. Swanson (2001) put it that “only the informants themselves can articulate what is relevant to them” (p.78). From my stem question I developed inter-related sub-questions. I frequently moved backwards and forwards in an interview, and used probe questions to encourage further development of a point to see if, as our conversation progressed, the speaker would elaborate or expand on earlier views about what spiritual care by a nurse was. I believed that, in adopting this approach, I would enable the study participants to share their experiences of nursing with me, a relative or complete stranger to them, bearing in mind that much of what they might talk about could be both sensitive and even controversial. As certain lines of enquiry emerged I let these develop and they were very fruitful and informative in my study. As Melia (1997) commented:

A series of questions and general lines of enquiry embedded in a seemingly natural conversation with the interviewee yield informal interview data. (p.34)

Individuals and community of knowers

Because the process of information collection changed over time, my questions changed similarly, as did the outcome or material collected. For example, when most nurses commented on the lack of support for themselves in nursing I started to ask other/subsequent interviewees specifically if this had also been their experience, and to extend my exploration of this aspect by asking what support structures, if any, there were. I tried to explore what it was about these experiences that could be spiritual. Usually this facilitated a fuller discussion of nursing care, its delights, dilemmas and difficulties as well as what was, or could be, spiritual, and what the nurse’s role might be. This approach to questioning and conversational discussion let me clarify the emerging material within theoretical constructs of spirit, spiritual care as MP&F and the nurse’s role, both within and between interviews. In the context of their experiences of giving nursing care, informal, conversational interviews enabled

me to ask theoretically oriented questions about the nurses' understanding of spirit and spiritual care.

These specific topics drove the interview process whilst new matters arose according to the experience of the participants. Content and approach were therefore adapted according to each participant's contribution. For instance, participants frequently asked for clarification as to what nursing students were currently taught about spiritual care in nursing. In presenting the core of these arguments I was often able to focus the conversation on spiritual care in nursing.⁴⁶ What was spiritual about care in the participant's nursing experiences was always central to the interview but sometimes time was spent discussing personal experiences in order to get to that point. This process contributed to the construction of the study materials throughout the study, and not just at the final stages of writing.

I sometimes used knowledge from previous interviews to pursue a line of discussion, saying for example, "Yes that is interesting – almost everyone has commented on that," or "What you think the reason might be, in your experience...can you go on a bit on that, it is really interesting." I think this helped the participant to feel part of a wider group of research participants and also allowed me to facilitate the testing of some theories of spirituality and nursing in the style of the conversational interview.

Discursive discussions

In discussing nursing roles, we frequently talked discursively in order to illustrate a point about caring and possible spiritual aspects. Where appropriate, I shared some aspects of my own experiences. Stanley and Wise (1983) criticised earlier feminist researchers, such as Oakley (1981), for not saying more about themselves during interviews. However, I found this quite difficult because my academic background had been objectivist. I endeavoured to elicit the nurses' experiences and views and minimise my own. This included reference to personal experiences of bringing up children and the illness and the death of loved ones, caring roles that remain predominantly those of women and have links with nurses' roles. This was not to say, though, that the interviews were merely friendly conversations since, although

⁴⁶ I discussed these important studies in Chapter One of my thesis.

they were informal and friendly, the interview was nevertheless focused on my specific areas of enquiry. As Melia (1981) commented:

Even un-structured interviews have an underlying structure. It is this which distinguishes it from social conversation [...] what is ultimately important is the frame of reference. (p.50)

Concluding interview conversations

In the last five minutes of our interview conversation I gave each person the opportunity to say anything about the topics which we had not already discussed. I 'debriefed' by asking what they were going to do next, and so the conversations ended on a positive note as interviewees talked about getting the meal ready, going to the hairdresser, walking the dog or similar everyday activities. This was particularly important since, as anticipated, we had sometimes discussed distressing personal and professional experiences and the interview process. As Charmaz (1995) described the interview process

...involves setting the tone, seeking information in depth, feeling and reflection, searching for the narrative and ending on a positive note. (p.5)

Consequently, as I thanked them for discussing their nursing experiences with me, almost all participants commented on the lack of any opportunity to discuss such experiences within their nursing practice, and, indeed, this was one of the principle reasons most had volunteered. Other feminist researchers have also noted this. Robson (1993) said:

Taking part in a study can often lead to respondents reflecting on their experiences in a way they find helpful. (p.297)

Each participant made me aware of the complexities of the issues we had discussed, not least the art and science of nursing sick people, and I often felt a real buzz of excitement about nursing. But I remained puzzled as to why nurses should also give spiritual care. A diary entry reflects this on-going questioning within me:

What was it about nursing practice that was so rewarding? I could not always put my finger on exactly what that was, any more than the participants could. Why do nurses now need to practise spiritual care? I wondered what I have been leaving out of my care all these years.
(Diary entry, October 13 2002)

This idea of shared experiences of nursing which we were unable to fully articulate was a recurrent theme in my interviews.

As soon as possible after the interview with each participant I wrote notes about any aspect of it I felt relevant. I noted any particular points about how I felt the interview had gone, and any particular points about the non-verbal language, and related interaction aspects of the interview, which might not be evident in the taped recording of the interview.

Ethical aspects of conversational interviews

Each participant was asked to sign a consent form (Appendix). However, there are wider ethical aspects to in-depth, one-to-one interviews where inevitably there is an exploration of innermost thoughts and experiences. Respecting each participant as a fellow human being, and therefore treating with courtesy and consideration any possible needs they may have related to the interview process, was paramount.

I ensured that all personal information about participants and those of whom they spoke was kept anonymous. This included names, gender, places of work, and names of patients and circumstances of care. Each mini-disc recording and transcript was labelled with the pseudonym of the participant. This process was so successful that when I met some of them elsewhere some months later, I could only remember their pseudonym. However it was necessary to use the individual's proper name for purposes of mail and other correspondence. Information was stored on computer and file folder in my personal home-based study e.g. 'Interview 3 – Jane.'

Once the interview was made into a transcript it became more formal and more accessible to others. Consequently, study participants had a right to see and agree to their use in the research study (Yow 1994). I sent full copies of the transcripts to each participant and asked them to let me know if there was anything they either did not

recognise or would not wish to be included. Following ethical guidelines about conducting research interviews and storage of materials, there had to be a relationship of trust between me and the participants that I would use all materials responsibly. However, there is debate about the extent to which information given by way of illustration may be interpreted, or misinterpreted, by the researcher, since ambiguities or misrepresentations are obviously possible in any creative endeavour (Norris 1997). Furthermore, Lincoln & Guba (1985) commented that revealing detailed descriptions of their own or other people's experiences may jar their self-image or professional perception of what was right to say. This was evident in with one participant, Isla who replied that she was very unhappy with some aspects of the transcript. Although she had trusted me in the telling, when she saw it written in black and white she was anxious: *I must say it looks very raw and abrupt when in writing ha-ha!* She asked me to remove it from the written account but agreed to let the account of her experiences remain when I reassured her of anonymity. Several participants said they would like to see the finished thesis and I said I would endeavour to send them relevant parts.

Transforming and understanding the interview materials

I prefer to call the outcome of my research process 'material' rather than 'data' since the latter is so heavily over laden with connotations of objectifying research. Although analysis and interpretation was a continuous process of comparing one piece of information with another, both within and between interviews, it was nevertheless in the final stages of writing my thesis which was predominantly the

...process of envisaging patterns, making sense, giving shape and bringing your quantities of materials under control. (Ramazanoglu & Hollands 2002:160)

Computer assisted programmes

My original intention was to use a computer-assisted qualitative data analysis (QDAS) such as NUD.IST (Non-Numerical Unstructured Data, Indexing Searching

and Theorising: Qualitative Solutions and Research Pty Ltd.) to support both storage and retrieval of research material. However, imposing computer programmes seemed to me to be a form of positivistic method overwriting both the context and subjective voice of the individual. As Mauthen & Doucet (1998) commented, computer programmes give an “air of scientific objectivity onto what remains a fundamentally subjective, interpretative process.” (p.122). I was unsure that computer software would enable me to keep the information ‘in my head’ so that I could see, find, or create links between the analysis and interpretation of my material within the context of the conversations. Wolcott (2000) remarked:

Computers are so engaging they draw researches away from the central task of thinking about their research focus and into data-entering ritual that is often tangent to the research problem itself. (p. 44)

Because I felt the context described in conversations was important, I wanted to “code the moving picture as well as the snapshots.” (Catterall & McLaren 1997:1) This form of analysis requires a moving back and forth across interview transcripts, as I had also done with the structure of the questioning in the interviews. Evidence from users of the ‘on-screen’ process suggested that it led to fragmentation and decontextualisation of the process aspects of the research where the whole was lost to the parts. Furthermore, I was unsure how using computer analysis would enable me to relate the interview materials to the wider interdisciplinary framework of my study. Although Strauss & Corbin (1990) argued that theoretical perspectives were integral to computer coding as a form of analysis, Webb (1999) argued that, in a small scale study, it is the researcher who has to use judgement in interpretation of the data and computers may not facilitate this process. Consequently, rather than use QDAS I decided instead to do the analysis manually.

Transforming talks to transcripts and texts

Within the first few days after each interview I listened to each mini-disc recording once right through, and again several times, in sections, during the word-processing. In this first step in reconstructing conversations into a research story I felt I was

already imposing a distance and objectivity onto the immediacy of the intersubjective approaches. What had been lively real-world conversations had been relived in the writing but were now on a flat black and white page. As Birch (1998) expressed it: “I was left with a text.” (p.179) It was difficult to convey the richness of beautiful, lilting, mostly Scottish, accents, as well as the range of tones of expression, both verbal and non-verbal - from amused to angry, soft to surprised; the pauses, sighs and laughter. Along with most qualitative, feminist researchers, my aim of keeping myself as a participant in the research process and the resulting written text through self reflexivity helped to minimise, if not eliminate, the distancing between myself and study participants. However, Drew (1989) remarked aptly that “The symbolization of experience with language never satisfactorily captures the entirety of the experience” (p.436). Now I faced the task of getting the text to thesis. Creation of a textual world, acceptable to academia, has been recognised by Smith (1989) as

A central problem [...] the continual and powerful translation back to our beginnings [...] whether our own or others, into the textual forms of the discourse placing the reading and the writing subject outside the experience from which she starts. (p.35)

I revisited this feeling several times when I came to tease out the different layers of understanding in the analysis and interpretation of interview conversations.

Developing meanings in themes of spirit, spiritual care and nursing care

I listened for differing meanings in the contexts of nursing and the individual's personal life throughout the whole interview process, not only during the analysis and interpretation stages of the interview transcripts. This involved an on-going “trawl for key factors” (Savage 2000:1494) to enable me to locate the discussion in a larger academic debate about the nature of spiritual care and nursing care. Initially, I made hand-written notes at the side of each transcript as I transcribed each recorded interview conversation.

Codes and concepts

Drawing on the system of coding and comparative analysis common to grounded theory (Glaser & Strauss 1967), I tried to use the system called ‘open codes’ to denote the concepts around which interview conversations had revolved, namely ‘spirit’ and ‘spiritual care’. According to Strauss & Corbin (1990), concepts are described by their properties, and then grouped with similar concepts to form categories. I found this process exceptionally difficult because of the way the conversational material had emerged differently with each participant. It was difficult for the nurses to describe or define the spirit, or spiritual part of a person, for which they were being asked to care. For instance, ‘spirit’ was variously described as ‘essence,’ ‘self,’ ‘person’ or ‘something’. The study participants commonly voiced variants of “*It is difficult to say what it is*”. I repeated this process of attempting to code materials with descriptions of related topics, namely ‘nursing care’; ‘MP&F’; ‘personal definition’; ‘professional definition’; ‘nurse’s role’; ‘personal information’; ‘length of time in nursing’ and ‘types of nursing experience’.

Theoretical themes

Continuing to draw on the approaches of grounded theory and narratives I went on to try to group the interview material into theoretical themes – differing views of spirit and spirit and spiritual care and so on. To analyse each topic accordingly, I compared the descriptions of spirit and spiritual care within and between each transcript as they emerged, demonstrating their similarities and differences and drawing on related theoretical questions grounded in both the interview materials and existing related theories. For instance if a nurse described spirit/ual as being the inner self or energy, I compared this to descriptions by others, as well as to theories of the inner self, person and essence. However, including relevant interdisciplinary theories along with the interview materials disrupted the flow of the interview materials and more importantly the voice of the individual participant. Consequently, I decided to reduce the theories necessary for interpretation and analysis of interview materials and to include more of these in a separate chapter. This made Chapter One longer and more diverse than was manageable at times, but it was necessary to both set the study

materials in a wider academic framework and allow the voice of individual experience of nursing to be heard. I endeavoured not to create a gap between what nurses told me was their practice, and what I reported by virtue of fitting their accounts into a particular method or theoretical framework (Fairbairn and Carson 2002:17).

Dilemmas of individuals and communal context

As I proceeded with analysis and interpretation of interview conversations, I was concerned that dividing up the material into codes, categories and themes was dividing up whole individual experiences of nursing. There were two main concerns: one was how to represent individual experiences of nursing, and the second was how to maintain these in the context of the broader context of nursing. I felt I was imposing objectivity onto complex, subjective, human experiences. This was not in keeping with my selected qualitative, feminist epistemology and method, where knowledge and understanding arise from subjective involvement with the topic and participants, rather than adopting an alleged objective, detached stance (Harding 1993). Did I need to have individual views represented in detail? By this stage of analysis and interpretation, I felt I did, because of the way my conversational topics emerged. I particularly wanted, therefore, to maintain the individual experiences as well as their context. Other feminist researchers experienced this dilemma in the analysis of transcripts. Mauthner & Doucet (1998), in their studies of women as mothers and of domestic relationships had faced similar dilemmas in representing personal experiences. They found that subjective, personal, reflective processes are not well represented by the action/interaction of grounded theory since the latter is less interested in 'persons *per se*' or this personal voice (Strauss & Corbin 1990:177). In the process of categorising spoken and recorded words into themes for analyses, Mauthner and Doucet (1998) pertinently commented:

...the data analysis stage can be viewed as a deeply disempowering one in which our respondents have little or no control [...] the discreet separate individuals interviewed are gradually lost. (p.138)

Birch (1998) described how she felt she was losing sight of the whole context of the individual story recounted in the transcript once she

...started cutting and splicing, linking and indexing, I felt that the nature of the story and the social setting disappeared. (p.179)

Difficulties with articulating nursing

Many participants had either found difficulties in articulating individualised, personal, nursing care, or had found that, directly or indirectly, organisational or medical care structures effectively diminished the value of such care. Because of this, I questioned if the way in which the nurses told me what they understood spirit and spiritual care to be was actually part of the understanding I was seeking. I was struck by the ways that the nurses found it hard to say what spiritual care was and also how they linked spirituality to suffering, albeit often indirectly or unwittingly. I questioned if it was similar to Morse's account of her years of research into comfort by nurses when it was suffering that was the actual core concern of patients (Morse 2001).

Locating conversations in a wider theoretical community of knowers

In the final part of my thesis I interpreted the stories in a literary and theological consideration of suffering as spiritual, drawing on feminist standpoint epistemology and feminist informed theologies and spiritualities to understand why nurses described their caring experiences as spiritual. To interpret these accounts within the theoretical framework specified, I read and reread the interview transcripts many times again and used sections of stories that helped me understand why nurses may be asked to give spiritual care.

Summary

In summary, because the overlap between the nurses' own attempts to say what they thought spirituality was overlapped with and indeed was often intertwined with their

personal and professional accounts, I found it as hard to separate these as did the teller in the telling. Indeed, it became a consistent theme of my study that nurses could not usually distinguish the one from the other. To separate them would make the outcomes different to what actually transpired during the open-ended, creative interviews, where life-stories merged with professional experience. This became part of the way nurses said what they believed spirit/spiritual care in nursing to be. If nurses are to give specific spiritual care it is important to understand what it is, and why it is necessary for nurses to give it. It is to understanding these interrelated questions I now turn in my thesis.

CHAPTER THREE

Spirit and spiritual

It's difficult because everybody sees spirituality differently we all have our own spirituality and I think we're exploring it all the time...I think we're all self-discovering all the time, learning about ourselves all the time. I would say it was that.
(Isla - Study Participant)

As discussed in Chapters One and Two, the theoretical framework that drove the development of the content of the next three chapters was developed from the existing studies by Ross (1992/1997) and Bradshaw (1994/1997), within the broader interdisciplinary context of traditional and contemporary spiritualities, nursing and feminist informed theologies.

In this chapter I explore what the study participants understood by spirit and spiritual. I have already discussed the lack of agreement as to what spirit is in nursing and literature from relevant theories in Chapter One. Spilka et al (1997), in a scientific examination of *Unfuzzifying the Fuzzy*, concluded that the concept 'spiritual' "embraces obscurity with passion" (p, 549), whilst McSherry (2002) found in his study that a significant number of people found the term 'spirituality' meaningless, and positively disagreed that their lives had a spiritual dimension. This ambiguity, and even confusion, made it imperative that I should explore further the ideas of spirit and spiritual if nurses are to be taught to practise spiritual care with patients. As I discussed in Chapter One, the dominant discourse on spiritual care by nurses described spiritual care as so absolutely necessary to good patient care that it should be taught and added as a distinct nursing care category (Ross 1992 1995). Whilst the individual and often non-religious nature of spiritual need in most people in Britain's largely secular society was recognised, it was nevertheless agreed by the authors that all patients had spiritual need. On the other hand, spiritual care was thought unnecessary, since nursing is itself spiritual care (Bradshaw 1994 1997). I used these categories of spiritual care described by Ross and Bradshaw to explore what nurses understood them to be, rather than develop different labels for the same phenomena. Morse (2001:214) argued this was important in qualitative studies as it minimises the

risk of confusion with the emerging categories on the one hand and, on the other, congestion of the concept in existing research. As I discussed in Chapters One and Two, the concepts ‘spirit’, ‘spiritual’, ‘body’, ‘caring’ and even ‘nursing’ do not have fixed boundaries, so there are inevitable overlaps in understandings.

The nurses not surprisingly found it difficult to separate what they thought of as the spiritual part of a person from their experiences of nursing care of the whole person, and even their own personal life experiences. Thus, the divisions in this chapter and the following two are merely technical devices for presenting the thesis. However, in reality, in the ‘situated knowledge’ sense, they are indivisible, and this is the crux of my research question, as I discuss throughout the following chapters.

Spirit and spiritual: it’s difficult to say what ‘it’ is

Sensitive issues

As talking of personal beliefs and sensitive issues can be difficult (Farquhar & Das 1995) I tended to enquire of the nurse’s own spiritual beliefs well into the conversation, often nearer the end of an hour talking about nursing. This gave the nurse, and me, time to settle and feel more at ease with the topic, and each other. I used this approach with almost all participants. Some felt entirely at ease talking about their own beliefs from the start. Usually this was if they had very clear Christian conversion experiences. Caitlyn told me at the beginning of the conversational hour that she was a Christian. However, she was in a minority – of eighteen participants, only three were Christian, and one of those was hesitant. With most participants, therefore, beliefs became apparent during the conversation; with others it was less obvious. This was where my own wide background in religions - my ‘insider’/outsider’ stance - was invaluable in understanding the frame the person used to structure her human life-world. Even so, I found that almost all nurses appeared to find it difficult to talk about their own spiritual beliefs. *It’s difficult, why did I embark on this?* Jane exclaimed and said at a later point in our conversation:

I feel if you are a spiritual person you do - I can't explain it. This is really hard!

It's ok, I didn't mean it to be hard, sorry! [Laughter +]

Usually I approached the subject whenever I judged the nurse was comfortable in the conversation, though sometimes I either misjudged this or the person was quite anxious to please throughout, as with Jane. During probing of her understanding of what she understood by spiritual care, Jane went on to exclaim: *This isn't good for my brain! Martha Rodgers⁴⁷ and this in one day!* I returned to the theme later in the conversation, when we had been talking about her interest in Buddhism:

You kind of link it up with Buddhism, Reiki, different expressions of spirituality if you like, what would you say when I ask you what spirituality is?

It's such a hard thing to define.

Nearly all study participants found it difficult to say what they believed the spirit or spiritual aspect of a person to be, and in trying to verbalise it, they usually referred to their own beliefs or experiences of nursing. This was demonstrated from an extract in the conversation with Isla, who worked as a Staff Nurse in the acute surgical ward of a large university teaching hospital, and was also studying to become a Complementary Therapist:

[Pause] *hm difficult isn't it [laughter] I've learnt more on this course⁴⁸ I am doing about spirituality. It's a very individual thing it's such an important part for that person.*

So what is the IT you think is important?

Quite a bit later in the conversation:

Ok what do you mean by IT?

Spirituality just the [laughter, more relaxed now] I don't know

⁴⁷ An American nursing theorist.

⁴⁸ BSc in Complementary Therapies included modules in Spiritual Healing.

Right I keep coming back to this cos you've obviously got somewhere deep in there, and I think you're trying to search for it yourself possibly - is that what actually spirituality means to you?

Forty minutes into the interview conversation:

Right so this getting IT [spiritual care from the nurse] you seem to have some idea in mind what IT is ...can you expand?

So what is involved in teaching spiritual care to nurses nowadays?

Here I wondered if Isla was avoiding the discussion because it seemed too complex or whether I needed to approach the subject in a more practical way. This self-reflection persisted throughout the interview processes. Almost at the end of the hour of our conversation I tried again to clarify what this individual person believed for herself about the spiritual part of a person:

Do you believe in the spiritual part of a person or - ?

Absolutely yes it's a basic I think it's something that is very basic just an individual part of that person.

After a discussion of current developments in teaching spiritual care in nursing with Isla I returned to why I was trying to get a 'handle' on what spiritual care in nursing might mean:

So this is why I keep coming back to well what do you see as spiritual part of a person for example?

I think it's the uniqueness of them...uniqueness, something that em [pause] something that is [sighs]

Right, their uniqueness?

Here Isla shows how difficult it was for her to say what the spiritual part of a person is, whilst at the same time she regards *it* as absolutely basic though it can be *uniqueness, basic and individual*.⁴⁹

Following such interview processes I wondered if I was too focused in trying to get the participant to say what she thought the spiritual part of the person was, and if

⁴⁹ I discuss this later in this chapter.

this may be due to my finding it difficult to step out of my teaching role into that of a researcher. A note in my reflective diary said:

Um I see why feminist researchers as well as others talk about the need to think about power hierarchies cos even though I don't think I am that sort of person as a teacher or a researcher perhaps she [the participant] thinks I am or maybe it's a combination of that and the sheer difficulty of getting at what on earth spirit or spiritual **is!** Still as Hammersley says, even feminists can't get rid of research hierarchies in all their research (Hammersley 1995:60) (November 13 2002)

Spirit as religious/cultural

In Christianities there can be differing beliefs about the spirit and about spiritual care. Indeed, as I discussed in Chapter One, Ross (1992) separated spirit from body in a hierarchy of needs whilst Bradshaw (1994) located the meeting of needs in bodily nursing, arguing this was itself spiritual. Each of the three of the nurses who said they were Christian also had variable interpretations of what the spirit/ual was. Judy volunteered the information *I am a practising supernaturalist*⁵⁰ *'Christian' in inverted commas*, at the start of the interview. Expecting a conventional Christian approach to the supreme importance of the spirit to be united with the transcendental God, I found Judy refreshing:

I'm not sure how happy I am with the concept of spirituality...I think in a pluralist culture, I think it's very difficult to agree what it is and I think it becomes so vague it doesn't mean anything...I just don't like the term 'spirituality' you know I don't think it is terribly helpful.

Judy believed spirituality belonged to religion, specifically, Christianity: *'Do you want me to bring the minister?'* would be, very obviously spirituality, she thought.

⁵⁰ A supernaturalist believes in miraculous powers as divine and beyond nature (Radin 1997:18). In pre-scientific times almost all natural phenomena were thought to be under the control of supernatural forces, or spirits. Naturalists, however, argue that so-called mysteries are inherently biologically explicable (Dennett 1991) whereas supernaturalists argue that mysteries beyond natural explanation are no less subjectively experienced.

But to give spiritual care herself, even as a religious believer, posed problems for her as, she said, *it presupposes some kind of conceptual framework that we all agree on, and we don't...*

An experienced Stroke Specialist nurse, Judy found trying to define what the spiritual part of a person was, in nursing, as difficult as trying to define madness:

I still haven't seen a satisfactory definition of madness and I suppose madness as a term is less useful as a term when you start to unpack it and I think the same about spirituality, it is not a helpful term and...but you're telling me to believe in a supreme being that's as crazy as Santa Claus?

Here Judy expressed difficulties with both the concept 'spiritual' - *I think the same about spirituality, it is not a helpful term* and the idea that nurses should be expected to give spiritual care, the focus of my research question. Given that she was a Christian believer this was a surprising and interesting find for me in our conversation. *Where are we coming from?* she mused. Judy had *concerns about* [the spiritual] also because of *it being so fuzzy* Judy surprised me by going on to tell me

And even for me as a Christian, I would have difficulties with the concept of spirituality in terms of separating body and spirit, as that wouldn't be my understanding.

The development of an emphasis of spirituality and holiness separated from the body was arguably to the detriment of women and the body, as I discussed in Chapters One and Two. This made me question why nurses were being asked to give spiritual care, as it did Judy: *I've come to nurse people; haven't come to be a minister or priest or something like that.* She rather believed in the Judaic approach that did not divide life into physical mental and spiritual,

...so for me, spirituality involves the body Spirituality might be looking at somebody from a slightly different direction but it wouldn't be a separate bit of them well, my understanding as a Christian is that the body/spirit divide came through Greek thinking really.

As Judy identified above, separating a person into body, mind, and spirit

isn't a Jewish concept at all, so from a Jewish side of things, you would just talk about the whole person, I think.

Here, similarly to Bradshaw, Judy was basing her views on the teachings of Jesus the Jew derived from the Hebrew Bible/Christian OT from which Jesus drew his life and teaching. This focused on how man should live, so as to re-establish and maintain peace and wholeness, individual and communal, where both the individual and society or community are inseparably linked, the one causing or relieving disease. The great commandment of Judaism was the *shema*, that man's duty is to love and serve God with all his heart and mind and soul (Deuteronomy 6:5) and his neighbour as himself (Leviticus 19:18). These deeds of 'loving-kindness' were particularly to the poor, the leper, the lame and the blind. To do these deeds was to practise righteousness, *tzedekah*, which meant 'salvation' in Hebrew teachings (Matthew 25:45-46). Salvation was not about having an individual soul or spirit for a transcendental world but was about how to live in community: the health-giving peace '*shalom*' can only be found by doing righteousness and goodness to one's fellows. In the Last Judgement the single criterion will be whether or not a person has been merciful to his fellows, as Vermes (1993) explains, to Jesus as a Jew: "The prize of salvation is awarded to those who have acted with generosity towards a God in disguise" (p.204). In later Christian teachings, however, the state of an individual's spirit, or soul, had to be saved to ensure eternal life, or a life to come in another, spiritual, world, namely heaven. Therefore, the spirit became supremely important but salvation came to mean something quite different to the teachings of Jesus.

Whether Christian believers or not, in most nurses' experience it was only with religious believers that the need for specific spiritual care arose at all. Here, the nurses felt that knowledge of that tradition helped them to understand the patient. Here they could understand what the notion of 'spirit' was to those patients. For this reason an understanding of religious spiritualities was valuable. Jackie said:

I think people are comfortable with labels so if you call it God or Mohammed or whatever you call it actually think they're all the same.

Specific spiritual need was usually met through the nurse liaising with the relevant minister of religion. *You would contact the religious groups* was how Dawn expressed her experience of spiritual care by nurses because, she said, *I see spiritual care as religious*.

Where staff shares a patient's belief system they may bring support to patients. A religious nurse or doctor can bring comfort and support to a patient who shares those beliefs and/or practices. A note recording and reflecting on a meeting with one of my PhD supervisors, who had recently been an emergency surgical patient, confirmed this:

She said an anaesthetist noticing her clutching her rosary beads said: "I see you believe in Jesus like me. I am a Coptic Christian...the peace of God be with you." And she overheard an elderly woman praying: "Dear Lord, take care of me in the operation."

(Supervision meeting/Personal Communication 08/08/03)

In Caitlyn's experience the nurse *sometimes would read the Bible to them if they wanted that, it always came from the patient, what they wanted* and Jane thought *it's about religious aspects, to be able to practise their own religion*.

Cultural/religious

Mostly, where nurses knew patients had religious faith, they thought the relevant faith representative should be involved in this aspect of their care and that the nurses should facilitate this, but not necessarily be any more involved. Indeed until the advent of recommendations that nurses should give specific spiritual care to patients, facilitating religious practices had been the norm in nursing practice. Insofar as nurses did practise 'spiritual' care, it was in the context of cultural and religious aspects of care, with the focus on holistic bodily needs, such as diet, dress, hygiene and language, as well as facilitating religious rituals (McGee 1992 Schott & Henley 1996 Neuberger 1996).

If the nurse had worked in parts of the world where there was a strong religious culture or in Britain with people from ethnic minorities, the knowledge of these was said to be very helpful in nursing people. Many cultural traditions other than the

Christian (-ised) do not single out spirituality since it is the ethical and cultural practices which give meaning and coherence to life (Whaling 1986, Hinells & Porter 1999). Agnes, for instance, said when she worked in a small village in South India with a NGO⁵¹, she noticed that

they have, yes strong belief in life force something which is in everyone's everyday life, and a lot of rituals in terms of very superstitious beliefs and practices lighting incense sticks and going to the temple giving puja worship for all kinds of things I think probably very supportive thing for people.

This had been Lillian's experience too when she worked in London where she said it was the patients from Hindu, Sikh and Moslem communities who had been the only patients requiring religious/spiritual care and that the families of faith communities attended to these needs:

I've looked after Jewish patients especially down in multicultural London, and Asians, and Hindu, Moslem, and in that case we couldn't get anywhere NEAR the patient for the family! We had to clamber over them to check the pump!

For Lilian, the only patients who had spiritual needs were from non-Christian religions. In such cases, she said, nurses were not required to do more than facilitate cultural/religious care and practices.

Jackie, who like me had travelled around the world as a child and also been to an international school in central Asia, had

trained at [large city teaching hospital] where we had a large multi-ethnic population so I think we had an awareness of different people's beliefs again and as I had them growing up it wasn't such a big leap.

Where the patients had a religious belief or faith, the nurses felt that knowledge of that tradition helped them to understand the patient. As Christian believer Caitlyn from the Caribbean said, people there

⁵¹ Non-Governmental Organisation.

read the Bible and prayed and had a church...they would often open up to a nurse about what was happening to them... a lot of people prayed themselves better...couldn't always work - for instance if they had cancer or a bad stroke - but often it did help... it was all just part of it [nursing care] except if the patient asked for spiritual care themselves such as if they wanted someone to pray for them etc. we would ask for that e.g. call in a minister or sometimes we read the Bible to them if they wanted that...it always came from the patient...what they wanted.

It's how you live your life

Jackie described herself as a practising Christian. She had been brought up in Christianity as well as rearing her own children in it. She said *it's about how you live your life*, a theme which others, like Jane, echoed:

if you try to live your life not harming people, and trying to comfort people, or help them on their way - that sounds really twee –

Jane believed being spiritual was about *Karma*⁵² *and you'll reap what you sow, about how you behave as well, you do try to behave so you don't harm other people. Karma determines the progression of the individual self*⁵³ *through a series of rebirths of dying and becoming, or samsara to the experience of Nirvana. For this Enlightened state, according to Indic and polytheistic traditions, even the Buddha, or Enlightened, or Awakened One, needed seventy-five such karmic rebirths. Jane for example said to me that she thought I must have come from India in my previous life [laughter]*

⁵² *Karma* is the moral law in the universe and is the process which determines the consequences of actions on the person performing karmic actions. Actions are seen as both practical and spiritual as they affect the passage of the Atman through samsara - good karma brings better rebirth so avoiding bad karma and striving for good karma is the ultimate goal to prevent the cycle of birth and rebirth, itself perceived as suffering in Buddhism (Bowker 1970; Thomson 1999).

⁵³ Of course there are many different interpretations throughout Indic scriptures and traditions which I cannot enter into here. For instance the 'self' can be thought of as divided between the embodied and socially determined by caste whereas the other self is the Atman related to the whole expressed as Brahman. Part of the Hindu sacred scriptures Upanishads Bk. 111, 14:3-5 argues that the Atman and Brahman are one single reality, globally represented as Brahman and as Atman as self. *Moksha* release is achieved when the individual realises he is not separate from Brahman but that his Atman is an aspect or manifestation of Brahman. The latter is realised by following the *Dharma* which can be understood variously as truth teaching reality or order of the world as timeless structure and meaning; with a small 'd', *dharma* can mean 'thing' to some Buddhists. However not all Hindus accept the doctrine of samsara, just as not all Jews or Christians accept the doctrine of an absolute transcendental God who gave timeless laws, in the Ten Commandments, for example.

However on further discussion of karmic rebirths she told me she was not a member of a Buddhist or Hindu faith group as I wondered but that she was *fascinated in things from the East* and then conceded that although she believed in *karma* she observed *that you do see a lot of people doing really bad things which they don't seem to be punished for - it's hard to swallow*.

Similarly, Jane told me of a Moslem patient she had nursed who believed Allah had punished him with his pilonidal sinus⁵⁴ because, instead of washing after toileting, as taught in Islam, he had used toilet paper.

Dawn remembered a Jewish patient who died and the nurses dressed the body and did not know what to do or not to do. As she had worked for several years in multicultural Hong Kong, Dawn knew the importance of not offending

Hindus and Moslems and halal food - different kinds of kosher food, not mixing meat with milk, that kind of thing, as it is very important to the spiritual side of people from these religions...they believe there will be retribution if they do not follow the rules.

From a Christian perspective this was expressed by Dawn as *you should be a good citizen, live by the Ten Commandments and rule of society and about being a good person or live a good life*. Jackie said she would consider that as much about spirituality as saying *'I go to church every week'*.

Spiritual care by religious believers

Reading to a patient from the Bible on a patient's locker had been the impetus for Ross (1992) in her doctoral research into *Nurses' Perceptions of Spiritual Care*. She also found in her study that it was those nurses who had a religious faith who were more perceptive about spiritual need in patients. It was acknowledged by nurses in my study, also, that where the nurse shared the same or similar religious beliefs in the existence of 'spirit' then this made it easier to enter into that patient's spiritual

⁵⁴ Pilonidal sinus is an opening above the anus which tracks inwards and becomes infected, usually requiring surgical debridement and painful post-operative dressings (Gillespie J. et al eds. (1995) *Guide to Surgical Principles and Practice* Edinburgh, Churchill Livingstone pp394-5).

thought-world. This reminded me of the focus group I had held at the beginning of my study and which I discussed briefly in the previous chapter. I found that the same phenomena recurred with students and colleagues over several years in teaching:

Interesting yesterday doing sessions 5&6 with students. When asked them what they thought of as spiritual in their lives they said they couldn't separate out idea of spirituality from religion and that wasn't important to them. Also interesting that none of them saw it as the nurse's role to do more than facilitate religious practices – call the chaplain etc particular request for dealing with religious/cultural practices such as food and modesty which one student described as causing difficulties recently with nursing an elderly Moslem woman. (Reflective Diary Entry 12/03/02)

And:

Interesting that the religious ones are very confident to the point that they wish to dominate others' views but those who are NOT religious take quite the opposite view and are generally indifferent but politely interested in the class! One or two though get very annoyed about it being seen as a nurse's role. One student said today that he had heard of a Satanist priest/chaplain being appointed to a naval ship; what, he asked would I do as nurse if I had a Satanist in the ward? How could I respect his spiritual/religious wishes to practise his beliefs and weren't we being a bit ethnocentric in saying what we did about respecting everyone's spirituality? He had a good point I thought! (Reflective Diary 18/03/04)

Nurses who were themselves religious could see the importance of spiritual care. This linked with my own experience in teaching as my Reflective Diary entries above describe and also with what I found in the nursing and related literature on spiritual care by nurses in Chapter One, where Ross (1992/1997) and the dominant discourse advocated spiritual care by nurses, even if the patient had no religious affiliation or perhaps especially if this was the case (Burnard (1987)). Bradshaw (1994 1997) however argued that this was not necessary as nursing itself was sufficient for the patient's need for comfort and peace of mind, spiritual care being the preserve of the religious minister.

Ross had found that those nurses most likely to identify and meet spiritual need 'at a deep level' were more likely to have an awareness of God in their own lives, whereas those nurses who saw spiritual care as the role of the clergy only gave spiritual care

at a 'superficial level' (Ross 1997). Both of these ends of the spectrum, with numerous shades in between, existed in my study.

Judy, the experienced stroke specialist nurse, whose views on the spirit I have already discussed above, represented one extreme. She raised many concerns about nurses and spiritual care:

In some ways you might say that as a nurse you don't have any rights to address patients' spiritual needs at all cos people haven't come to hospital to have their spiritual needs seen to, they've come in voluntarily because they are sent through their GP who says you need xyz, or they need surgery, or they have a crisis at home and things are taken out of their hands and people are sent to hospital...I imagine there are very few people who dream that nurses are thinking about their spiritual needs or their spirituality or even that nurses ought to address it.

But Jackie, who was also a practising Christian, represented the other end of the spectrum. She was in the non-conformist social gospel tradition, which focuses more on practical social matters rather than transcendental spirituality, so to my surprise, she thought spiritual care was an important part of the nurse's role. Although Jackie thought *spirituality is not necessarily religious*, she thought however that *obviously it is a hook people hang their spirituality on*:

I think it has been in terms of - maybe it's a personal thing because I think the minister isn't necessarily there at three o'clock in the morning when Mrs Jones has woken up you know in a cold sweat worrying about where she's going and all those things and it tends to be the nurse who makes here a cup of tea and sits and holds her hand um and allows her to talk

On the other hand, Jackie did not think only religious spirituality was everything. She said *I think religion is an aspect of people's spirituality; it's not the whole thing*.

Each of these nurses then presented a challenge to Ross's contention that those nurses with a deep personal belief in God give good spiritual care. Judy had personal belief but positively disagreed that nurses should give spiritual care, whilst Jackie, as a member of the more liberal 'social gospel,' argued the opposite. Jackie thought

What would be nice in nursing would be if nurses felt comfortable...giving people an environment where they can say uhm you know what they think...if they had an overview of belief systems and I think sometimes if nurses feel uncomfortable then patients would maybe not talk.

Joan was positive about the nurse acknowledging the patient's religious or spiritual needs though she herself was not a religious believer.

However, Jackie said:

I think patients just expect nurses - you are the person they just presume you, cos nurses have such a wide variety of skills, perhaps they do, although they maybe wouldn't categorise it as spiritual care they'd put it in the caring/counselling role; they mebbe wouldn't separate it specifically though, I think that's mebbe where they'd put it.

Agnes, speaking of her work in the community, said if people

had a strong religious faith which gives them comfort and meaning and guidance and whatever, and I know it gives a lot of support... most people have ministers who come in to home.

Discussion

The multicultural society made it difficult to agree what the spirit or spiritual was, since religious practices were specific and really only of relevance to adherents of particular faith groups. What would a nurse do if the patient belonged to one or other of these faith groups? For example, should a nurse be able to read from the sacred scriptures such as the Koran for Moslems; the Baghadavita and Vedas for Hindus? Where a nurse shared those cultures/faiths this would of course be possible; however there is a risk at least of being ethnocentric in assuming that nurses should only read from the Bible whilst those who value differing scriptures may not have such a provision by a nurse.

Moreover, there are different ideas as to what 'spiritual' is within these different faith traditions. This is only to be expected given that they represent millennia of human history across the world. However, the differing religious beliefs mean that no one

view about spirit and spiritual could be held. Nevertheless, some common denominators may be found. Because religious traditions have at least as much to say about how *humans* should live together as they have about any mystical transcendent, spiritual life, some study participants interpreted their idea of the spiritual in this way. Often these related to ethical behaviour, either about how life should be lived in general or about experiences in nursing patients.

Spiritual care or nursing care?

What, then, would spiritual care consist of? How might it differ, if at all, from nursing care? This was a question Judy was concerned with too, since she could see that calling the minister would be appropriate religious/spiritual care if the patient wished this, but she expressed anxieties about what spiritual care was apart from religions. Judy also said:

If I was a nurse going into college now, being asked to give spiritual care I'd be pushing the argument back to 'what do you mean by spiritual needs?'

Spiritual needs have been described by Narayanasamy (1991 1999), and others, as the need to give and receive love; to be understood and valued as a human being; the need for forgiveness and trust, to express feelings honestly and to find meaning purpose and fulfilment in life.

Hmm. If we're not clear it's difficult for a sceptic who is asked to help people in terms of transcendence. What do I do? I can prove you have a high temperature: there's a thermometer; and I can prove that paracetamol will bring your high temperature down.

If it is so intertwined with nursing care of the whole person, how would or could spiritual care be separated from religious cultural practices, or from nursing care? Also, how would these be part of the role of a nurse, even if she were a religious believer like Judy?

Even though most people do not claim to have any overt belief systems with which to connect, for nurses like Jackie it was the nurse's role to become involved in religious /spiritual care:

As a nurse ideally as a nurse you have to say it's not just the appendicitis or MS in bed three it's a person that's just been diagnosed with MS and how is that going to affect, not just their physical but all aspects of their care - you can't separate them and say we'll just do the physical bits now [...] [since] spiritual beliefs will affect [their] disease.

Many nurses, however, had not have felt this was important enough for them to deal with, some of the reasons for which were related to gendered caring roles and the lack of teaching or acknowledgement of care practices, which I discussed in Chapter One. There was the issue of nurses not seeing religious care as anything to do with them as Judy said above, and as Jackie found:

In my experience nurses are either at one end of the scale or the other: they're either very good at it or very comfortable with their own spirituality or they are uncomfortable with it.

Because of the long historical association of spirituality with religion in Britain most nurses felt that it was not something nurses felt comfortable with giving, unless they were themselves religious believers as we have already seen. However, there were some exceptions, as with Judy, who was concerned about the whole area of spiritual care by nurses. Consequently, as Jackie described, nurses were concerned not to be seen as 'God-bothery':

I think people, both patients and nurses, are uncomfortable being seen as God-bothery or pushing any one particular belief onto patients so rather than doing that, they don't do it at all, they just put that bit away and if they're not sure of their own belief systems then it's a bit hard to support other people.

... nurses felt very uncomfortable with it and thought 'well you know it's not really my role we've got um you know clergy within the hospital who will deal with all that and that's lovely you know we can always hand it over to them and they can deal with it.' 'I'm not going to talk about that, it's the minister's role or the chaplain's job'.

This was particularly the case when there was lack of time and resources for bodily care:

Short of splitting yourself what do you do? You do the IVs don't you and hope you have time later but then maybe that moment's passed and she'll say no no this isn't the time and they never get the opportunity.

Spiritual care as religious/nursing care

Whole person care could be compromised if spiritual/religious needs were overlooked by the nurse, as Joan described. This story told by Joan is so intertwined with nursing care that it was particularly difficult to separate out what she described as religious 'spirit' from nursing care and to do so would diminish the account of her experience.

Joan worked in mental health and talked of the way diagnosis and treatment was affected for good or ill by knowledge of religious spirituality. She described the 'spirit' as *the religious bit* and whether the delusions were related *to the spirit world sort of areas*:

I had a recent experience with a client that got me thinking about it where ehm in adult Mental Health some delusions can be very much based around some sort of spirituality whether that be religious and a god or whatever, or whether the delusion can be focused around the ehm spirit world sort of areas, and then as nurses I think we would try not to deal with that, or, deal with the person's emotions but too busy telling them I don't believe.

Joan's experience was that knowledge of religious aspects of what she identified as spiritual care was insufficient, and so the care of the patient was inadequate:

it was the religious bit and cos of the delusions and these things cos I work sometimes in acute psychiatric IPCU⁵⁵ we had a client there who self-harmed⁵⁶ and the self-harm was associated with delusions of being very much in touch with his God and having to prove his worth by cutting himself ehm so he would do some really quite awful things to himself and these were escalating as the more he had to prove his worth -because obviously to hurt his finger he didn't think it was enough for God - so he hurt his hand, so you know it was escalating out of control.

⁵⁵ Intensive Psychiatric Care Unit

⁵⁶ Also called self-mutilation or self-injury

Two issues arose from Joan's experience. One was that she highlighted the sensitive and difficult situations that arise for nurses caring for patients. A second was she felt her standards challenged in deciding how to act in the patient's best interests even though she had a great deal of experience and, indeed, as she explained, she was *the highest grade on the ward for all I was a bank nurse*.

Another was the further complexity of religious belief affecting the person cared for and the need for nurses to have sufficient knowledge about religious belief to seek specialist help such as that of a chaplain where necessary. Where these are intertwined, it became difficult to maintain competent care as in Joan's experience, *a bit of me as a nurse I thought it was ok to say 'well I don't believe that I don't like ignoring it' but I think I may be in a minority*.

The point here is: should it be the nurse's role to do more than that? Should the nurse give spiritual care to the patient beyond the already accepted boundaries of professional competence? Joan identified that the patient had spiritual need, but she also could identify the harm nurses could do patients when they did not have any knowledge of religious spiritualities:

and how they were dealing with it was using various methods, chemical medications just to calm the situation down when it became bad and... and I thought we're really just ignoring that just ignoring it without sitting down and saying you know.

At the same time she conflated spirituality with religion, and indeed, with caring competently as a nurse, *so I decided to use light restraint on the gentleman rather than medication whilst being compassionate, comforting and caring as a nurse by trying to understand the patient's perspective, so I sat on his bed and chatted to him about it*. Here Joan was able to draw on her knowledge of Christianity *and I know a little bit* to help give appropriate care to her patient, although, she said:

I am not a follower of a religion myself but I was brought up Protestant - and part of that got me thinking about this and I know it's not just - he actually defines his spirituality as following a Christian faith -

When nurses did not have any knowledge of religious spiritualities Joan also could identify the harm nurses could do - *they weren't putting anything into it - obviously a behaviour modification plan* and with other nurses regarding how best to understand and treat the patient - *I had a discussion with a nurse about how best to handle it.*

The other nurses did not consider the religious spiritual aspects of the patient's needs, *he [the nurse] was saying 'the way I have learnt about self-harm is you ignore it and that if self-harm is happening you just leave a person to it,'* and this was a source of concern and anxiety distress to her. She also graphically illustrated how as a nurse, even a relatively senior one, *although a Bank nurse*, she nevertheless had a conflict with herself:

I still have to do what's right - made me think but, but I was in a difficult situation I mean I have my ethics and things but I also have to follow any treatment plans.

Continuing our discussion from the nursing perspective Joan said

As nurses I think we would try not to deal with that, or, deal with the person's emotions but too busy telling them delusions are their illness, and I thought that's awful and I really got thinking about that, while doing that we're ignoring the person's spirituality, although the delusions may go, since the delusions are based on the spirituality the person has that has in some way fixed.

Discussion

Self-harm is a complex area since it can be interpreted as a cry of inner despair with inner existential angst about self-identity or a response to outward circumstances that cause inner pain and turmoil, such as sexual, social and emotional abuse diminishing the individual's self esteem, or a combination of these (Babika & Arnold 1997). Nevertheless, how would such existential angst is termed spiritual rather than psycho-social? Babika & Arnold argue that "More than any other human action, self-mutilation speaks of distress, torment and pain" (p.1) and, whilst psychological, sociological and philosophical discourses attempt to understand

...the enormous individual distress which underlie self-injury; In responding to self-injury, acceptance and validation are very important; however, it is of primary importance that individuals be accepted for who they are not because of what they do. (p.19)

However, many researchers in the field describe self-injury as a use of the bodily self as a refuge, and as a means of communicating to others the internal trauma to the self. But, if writers in the field of self-injury are right that the antecedents of self-injury lie in some form of traumatic loss or separation (Walsh & Rosen 1988), where the traumatic death or horror is relived through, and death itself denied through self-injury (Stone 1987), would spiritual care of the kind suggested by Ross et al be appropriate to the needs of the patient? Or again, in the psychosomatic field, Chassegeut-Smirgel (1990) sees self-harm as

...physical absence of a love partner (that is mother) and 'unable to bear the idea that the other's mind may be occupied with thoughts not centering on themselves' that this leads them to a state of dereliction, rage and despair such that they are always seeking a way back to the mother's body through self-destructive acts.

(Cited in Babiker & Arnold 1997; 16)

None of the experts in self-harm consider the cause to be spiritual or religious so Joan's experience was interesting. However it seemed to me that the patient's understanding of his religion was also complex and confused and that the mental health chaplain could also have been helpful in talking through some of the religious misunderstandings affecting the patient's beliefs and actions.

In my discussion of Joan's experience of nursing a patient who self-harmed I have deliberately tried to tease out just a few of the complexities of the context of nursing care into which nurses are being asked to give spiritual care. This is a 'feet on the ground' example of contextual or, as Haraway (1988) termed it, 'situated' knowledge. To be competent, Joan would need to know about different theological traditions and religious texts to understand why or how or even if

...the self-harm was associated with delusions of being very much in touch with his God and having to prove his worth by cutting himself.

Added to the complexities of the condition with which the patient is in hospital there is also that of religions and spirituality. Joan's experience demonstrated that the nurse would also need to know if this is a religious teaching or a delusion based in that teaching, and so on. Given that in the average hospital ward there could be around thirty people with varying degrees of complexities of care, this one patient-nurse scenario raises significant questions about spiritual care by nurses, even if it is located in religion and is therefore more 'grounded' than spiritual care per se may be. Whilst informed discussion about the cause of any illness or treatment is recognised as sound professional practice, the issue here is that there is a lack of understanding of the patient's religious beliefs. Obviously such care needs are already recognised in professional guidelines. Joan's experience, however, was that knowledge of religious aspects of care was insufficient and so the care of this patient was inadequate. She indeed identified his needs as spiritual though religious, and she might not have separated these had I been asking about religious care rather than spiritual. Again, though, had my study been about personal care or psycho-social care she might have spoken of the patient's needs under those terms, rather than spiritual, since his needs were to be understood and helped to prevent him harming himself physically, the cause of which was inner turmoil which had links with his religious beliefs.

Negative aspects of nurses' personal spiritual beliefs

Although Joan and Judy above demonstrated positive effects of understanding of religious spirituality, when nurses themselves however had specific religious spiritual beliefs, rather than patients, sometimes these could be detrimental to professional care. Speck (1993), writing from many years' experience as a chaplain working in palliative care, proposed that patients

...may need protecting from the over-zealous person (staff member or not) who feels they have a mission to bring people to a faith before they die.
(p.520)

Susan, now a part-time doctoral student and also working part-time nursing elderly people with dementia, told me how when she was a student nurse in the early 1990s,

the staff nurse chastised her for tying the big toes of a deceased patient during last offices. Susan was startled to hear the staff nurse's reason: the patient needed to walk through the *pearly gates of heaven* and so *if she tied his toes together* this would be impossible.

Eleanor spoke of a Roman Catholic midwife who baptised a dead baby *so its soul could go to heaven, though the parents were freethinkers*.

In neither of these situations were the patients or the parents Roman Catholic. Respect for the rights of the patient had been overridden. Although the Code of Conduct of the Nursing & Midwifery Council (NMC 2004) prohibits the imposition of beliefs on patients, these scenarios exemplify that when these beliefs about the importance of the destination of the spirit in the spiritual world, qua heaven (or Hell) are held strongly by the nurse, they can override professional guidelines.

I was reminded of the focus group at the start of my study where staff told of their distress when a life-long vegetarian was fed liquidised meat since the staff thought it would not matter to him as he would not know; as a consequence he had severe diarrhoea. Such disrespect for individuals was more important than adding spiritual care, they thought and I agreed. The competent compassion of which Bradshaw wrote (1994 1997) extends to such matters of care.

Secular spirit

Caitlyn had come to live in Scotland with her husband and family and had worked on night duty in Care of the Elderly for around a year. She observed

...a difference...people don't seem to pray themselves better like they did at home...it is a cultural thing...people were just more religious in the Caribbean...they would read the Bible and get someone, say the minister, to pray for and with them...most Caribbean patients believed in God and the Bible and praying to get better, or for peace to accept the illness.

This nurse had not worked in a mission hospital with a strong Christian ethos, as I had expected, but in a university hospital, so the dependence on Christian religious practices amongst the population she described was striking. It was reminiscent of

the situation in Britain until about thirty or forty years ago since when, even in traditionally religious communities, the numbers of people belonging to churches has declined by approximately sixty percent. It is estimated that only about 10% of the population today actively belongs to any religious group e.g. churches, compared to around 30% of British adults over the twentieth century as a whole (Bruce 1995:31-42). Even where religion and church membership were important, they have become steadily less so in the past forty years or so. In 1960, forty percent of the population sampled attended a place of worship weekly whereas in 2002, in a hitherto religious community, respondents described themselves simply as 'human' and "sixty seven percent denied any religious connection whatsoever." (Gaber 2003:12)

There had, then, been a paradigm shift from the traditional belief in the spirit as the soul given by a spiritual and transcendental God, as in religious spiritualities, to non-religious spirituality. This social trend is reflected by most of the nurses in my study. This applied to patients described and nurse themselves where most nurses said they had been religious, or at least brought up to attend church, had given up religious belief and practice. For instance, Isla, who had been one of the first Project 2000 trainees, described this well in saying how religious care had been the only way she had thought of spiritual care in her training only twelve years previously: *yes we'll get the minister, we'll get the priest we'll get the rabbi and I think that was it.*

The great disappearing act

Whereas many participants said they had been brought up as church members they did not now belong to a church or believe in traditional ideas of spirituality or God. As Joan said, *I have no direct religious faith myself, I don't believe but I was brought up a Protestant.* This was by far the commonest response to my enquiring if the nurse had a religion. Sixteen of the eighteen nurses in my study had been brought up in the Church but had now left. This social change was described as *the great disappearing act* by Jackie:

When I went to school you were C of E, R.C. etc and that was it really and you all had religious education and you were told that was how it was and no-one ever suggested there might be certain aspects you might feel uncomfortable with, or you were just told that was how it was, and

*...you were just expected to believe or not, actually you had to believe it!
And a lot of people just decided they didn't want to have anything to do
with it - the great disappearing act.*

When I probed a little further into whether the personal spiritual beliefs of Isla were religious or not she said *no, not really no*, whereas Angela, who had been a nurse for three years and was now training to be a Reiki⁵⁷ practitioner said that although she was not a believer in traditional religion, she nevertheless believed in angels. *From when I was very little I always believed there were angels watching over us.* She had retained some aspects of traditional religious belief. Susan had been brought up C of S *and my parents still go [to church] but no I don't any more* whilst Deirdre also *used to go to church but don't any more.*

Interviewees gave various reasons for leaving the church or the belief in God and heaven and hell behind them as they had grown up, but most often gave none at all. Lilian said:

I was brought up to go to Sunday School I went to church, I joined the Church of Scotland but to be honest it was just what was taught in classes at Sunday School.

However, not all participants felt they had left religion for good/it had not been an irreversible decision. Joan reflected *who is to say—when day comes I may change my mind.* Sometimes giving up religious belief and or practices related to the nurses' experiences of nursing, as Moira said:

I don't practice any religion I am not religious any more I used to belong to the Church of England but stopped going about ten years ago. It may be tied up with working with children with learning disabilities.

Agnes said:

⁵⁷ Reiki was transliterated from the Japanese of its origins in the early twentieth century by Mikao Usui. Reiki means 'universal' (*rei*) life force energy (*kei*). A Reiki leaflet describes it as a powerful tool for both physical healing and expanding our consciousness. Reiki healers claim that they are channels for transcendent god-like powers or 'the source' or cosmic energies (Sutcliffe 2003:184-5).

No I don't have a faith I don't have a feeling there is a God there for me ... and also I perhaps feel if there is it is not the God who can influence things but I don't personally believe in a God but I know it is helpful and comforting to others.

Jane, who had been brought up Church of Scotland, said *I don't really go to church, no, I do believe, I'm more of the Hindu philosophy.*

This move away from belief in traditional religion and spiritualities was demonstrated in the variety of ways that interviewees described their understandings of what the spiritual part of a person may be.

Spiritual supermarket

The majority of the nurses in my study used contemporary terms and variously described 'spirit' as 'self', 'something', 'essence', 'person', 'goodness', 'uniqueness', 'a core', 'emotions', 'energy', 'presence', 'me', 'it', or 'being human'. However, the nurses were not sure what these things were, except that they did not concur with what they remembered from their earlier experiences of what the Christian churches taught. Although participants in my study said that, in their experience, only patients who had religious beliefs showed any need for spiritual care, many spoke of religious and contemporary spiritualities as if they were synonymous. The main difference is that believers in contemporary spiritualities generally do not believe in or practise any traditional religion, although some belong to New Religious Movements (NRMs) which developed from the 1960s and 1970s. As we saw in Chapter One, NRMs emphasise the divinity of the individual self without recourse to a transcendental God. The purpose is, as Bruce (2000) put it, "to free the God within, to get in touch with out true centre." (p.27) As Berger (1963) said:

The other world, which religion located in transcendental reality, is now introjected within human consciousness itself. (p.41)

It is therefore at least questionable if contemporary spirituality means the same as 'spirit' and spiritual as used by religious people.

There's 'something'

Irrespective of religious affiliation, many nurses continued to believe in 'something' (other than material life). One nurse, Edie, who had trained and worked in acute psychiatry in the mid 1980s, was convinced that there was something spiritual because of a holiday she had spent in a house. She said:

I got a very uncomfortable feeling ...and I could feel people in the house they weren't there but it I could feel them - I couldn't wait to get out of the house don't think I am psychic but there is evidence that there must be something there because it couldn't be just the building, must be some sort of spirit.

In exploring with Lilian what she thought the 'something' in which she still believed might be, she replied *I don't know is the honest answer*. She was *Not sure what I actually believe, I don't believe in NOTHING* and Jane thought *there is some force somewhere*. Lilian said:

I do believe in spirits and I think they are watching us I don't think we are alone I don't think it is all about solid objects like the table here I do believe there are people watching over us.

In this way the nurses vividly exhibited the social phenomenon of 'believing without belonging' (Davie 1994). On the other hand, there was Jackie who was a 'belonger' as a church-goer but said she *didn't believe* so her views were some way between a believer's in terms of practice, but not in belief. Lillian's story was fairly typical of the nurse participants in my study:

I do believe there is something, but I am not quite sure what that is [laughs] and I have never really explored it any further which is why this [the research study] is interesting me.

This 'something' as spiritual has been said to be the new religion of the twenty-first century echoed in a BBC survey *Soul of Britain* which that showed 76% of the adult

population reported being aware of spiritual issues in their lives in 2000 compared to 39% in 1986 (Hay & Hunt 2000). As Judy, one of the three religious believers in my study commented,

...it may be in a secular society...whether it's Christians who have smuggled it back in under the term 'spiritual' or secularists 'yes' we've lost something here let's call it spirituality.

Spiritual kaleidoscope

In Jackie's experience *only recently people have realised there are different options*. The diverse perceptions of the spiritual represented a kaleidoscope of beliefs which was typical of both nurse participants and the patients whom they described. Jackie said:

I would consider it to be, you know, the whole spectrum, where you get your support from, is it from within yourself, is it a higher force or energy, call it what you like, but they wouldn't necessarily say I am Church of England or Church of Scotland, or they have been brought up as Catholic as children and their views have changed so they um because they've been involved in lots of things they've maybe taken aspects of different religions or belief systems if you like and I, like a jigsaw, 'well I like that bit it appeals to me' but I think if you said to them 'it's a code of living if you like' what do you believe in? What keeps you going...what is it that guides you? Where do you get your direction from...Well some people would say 'it is religion' some 'well I don't have a religion BUT ...Others would say it's about being a good person or live a good life and I would consider that as much about spirituality as saying 'I go to church every week'.

I quote Jackie's interview conversation at length here as it demonstrated what Lyon (2000) called a supermarket pick'n'mix approach to spirituality, "a shopping mall [...] of religious and quasi-religious elements focused on the self and on choice" (p.117) which I discussed in Chapter One. Individual choice encouraged selection of spiritual approaches described by Sutcliffe (2003) as

...a lifestyle cocktail of discourses from astrology to the Tarot, I-Ching, Zen, Sufism, Hinduism, rural communes [and] the inadequacies of the contemporary plastic-scientific world. (p111)

Spirit as energy

The spirit as energy or essence and other non-material manifestations was discussed frequently by study participants, especially by nurses studying to become Complementary and Alternative Medicine (CAM) therapists. It is to a discussion of these views of the spiritual part of a person for whom nurses were to care I turn here, Jane, who had been a midwife for more than forty years, but was now doing a Complementary Therapies course, described to me how she thought of spirit as energy: *the energy that is in the body you think I do believe there is energy.*

Although patriarchal spirituality has been said to be divisive of individuals and communities, Judith Antonelli (1982) argued feminist spirituality could be different:

Spirituality is a worldview, based on energy, a perception which includes the nonvisible and nonmaterial. It deals with the collective psyche (soul) of humanity. Ritual, astrology, the Tarot, dreams and mythology are symbolic languages emerging from the unconscious. Psychic energy (life-force creative principle) is inherently female and this is the essence of feminist spirituality. (p 400)

The energy or 'Energy' is sometimes thought to be a move away from a transcendental spiritual God, but sometimes the energy is thought of as God, or as being from God. Complementary therapy student Jackie said:

When you talk about energy and um things you know they [clients or patients] say 'are you talking about God?' and we say 'well not necessarily, but it may be the name some people give to energy if you like' so it's much more abstract so I suppose that's where I would feel we would move away from religion.

Jackie went on to explain that whatever the label, be it God, Mohammed, or energy, humans found it hard to grasp, but had a belief or hope that there was a *power or energy if you like which you recognise as a human being is bigger than all of us.*

Spirit as healing energy

The notion of spirit as energy was widely incorporated as spiritual healing. Because of its connections with spiritual healing it was not surprising that any nurse or CAM therapy student would talk about energy as spirit, though this was not an avenue I anticipated prior to interviews beginning.

The belief is that energy flows through the energy centres in the body known as *chakras* after the early Indic healers and as *dantian* by traditional Chinese healers. This was relevant to nurses in my study as those who were studying CAMs spoke of these beliefs/practices as alternatives to scientific medicine. Furthermore, they considered energy to be spirit, used by ancient healers and increasingly in CAMs as spiritual healing. Spiritual Healers⁵⁸ believe they channel the harmonious energy of the universe to effect healing of the individual. The healing energy is based on earlier work by Brennan (1988) who spoke of the Universal Human Energy Field (UHEF). This was based on her work as a space scientist at N.A.S.A. The existence of this universal energy in which she experienced healing led her to become a healer. Thus the Human Energy Field (HEF) is believed to be within people and shared by both healers and clients (Hedges and Beckford 2000:177-8). This is central in New Age thinking and practices (Beckford 1985).

Spiritual healing is not however connected necessarily related to any religious beliefs or groups.⁵⁹ However, the beliefs do have similarities with traditional religious views of God as transcendental Supreme Spirit, whose powers to heal are invoked in prayers and related petitions. Angelo (1991) for instance, claims that spiritual healing occurs when we reconnect to the Source of Higher energy in the universe which may be negatively affected in times of personal trouble such as illness. Furthermore, illness is thought to occur because of negative thoughts which cause imbalances within the energy fields because of accumulated negative thoughts and feelings (Patterson 1998). When we experience this reconnection to the Source then, it is claimed, healing energy flows through us, and we are healed. This is based on a belief in the

⁵⁸ In the United Kingdom Spiritual Healers are affiliated to the National Confederation of Spiritual Healers.

⁵⁹ Some Christian Churches, however, do practise healing; however this would be believed to come from the Holy Spirit of God.

interconnectedness of body, mind, and spirit of each individual both within themselves and with the wider universe. In this sense spiritual healing is considered to be 'holistic' (Patterson 1998:291).

Benor's (1992) study of nurses and their experiences of using the HEF in healing described the experiences in several ways, for example, tingling or pulsating, but heat was the most common sensation experienced by both healers and their clients:

...the woman says to me, because she's noticed this energy too...she'll tell me that I do stop over the places where she's got problem areas, and she will feel a pulsating from my hands...but I'm not aware that I'm doing it and it can go on for quite a while afterwards, get quite uncomfortable. I don't know how to stop it. I need it. I call for it [from God] and it comes. (p.52)

One nurse related the energy to God: "I usually try [to] what I call, centre myself, asking for help from God, before I start to massage I feel this energy." (Benor 1992: 52)

Nurses in my study described an experience of energy flow as healing energy, felt as heat in their hands, *you can feel hot and old spots* as Jane experienced, and pulsating in the part of the body over which they held their hands in therapeutic touch, or during a massage.

Jane was very excited as she recounted her experiences to me. However when I had a massage by a Reflexology student I did not experience heat, apart from that of the motion of a massage:

Today I volunteered as a 'client' for a Reflexology treatment by a student on the Complementary Therapies course. During the course of the one hour session in which she massaged my entire back with basic oils I felt ...the release of tension in my muscles was heavenly but I wouldn't say I felt it was spiritual, rather physical... I felt the massage had been amazingly good at relieving my tired shoulder muscles but I honestly can't see what is spiritual about it except that it did lift my spirits and made me happier as I was more relaxed and less stressed. But was this what is usually meant by spiritual? It's not my understanding of it but maybe I need to move with the times! (Reflective Diary entry 17/03/04)

Jackie also described her experiences of using Therapeutic Touch as heat in her hands which she identified as spiritual.

Spirit as energy in therapeutic touch

Energy related practices had been common to Eastern philosophies of Indic origin, particularly Ayurveda. Therapeutic Touch (TT) and Reiki therapies were also believed to be spiritual by some of my study participants. Jane said *there's somebody at work who does Reiki - she does it on staff - she's a witch. I'm not a witch.* Complementary therapists base their healing practices on use of energy.

Therapeutic Touch (TT) was developed by Dolores Kreiger in the 1970s (Kreiger 1979) as a means of channelling energy. Kreiger stated that the body was kept alive and vital by the '*prana*', a Sanskrit word for 'vital force' or energy which flowed around and through the body channelled by the chakras.

In TT the therapist puts their hands close to, but not actually on, the patient's body and using the positive energies of the healer to heal the patient. described how in class she had been *scanning around the body you're using your hands but no touching.*

Isla described with enthusiasm the effect it had on her as a therapist: *just the experiences I've had, it's enlightening - it's difficult to explain but you're - almost - you can be at peace.* I probed further to try to understand how this could be thought of as spirit. She was not sure as *it is hard to describe* but felt she was at peace as *everything around you just seems to dissipate* when giving therapeutic touch (TT). It seemed that, in this context, spiritual care was perceived as enabling the person to be at peace within oneself: As Jackie exclaimed with enthusiasm to my probe question on this

Yeh! Whether it's calm I don't know you feel at peace so I don't know if that's spirituality or – but I feel at peace you know and everything around you just seems to dissipate and from the therapeutic touch - I would say that's quite spiritual.

When I asked Isla if she was able to practise CAM in the acute surgical ward where she had been a Staff nurse for over three years, she said

The medical profession still seems to think 'get the symptoms done [...] let's get this person out and we can fill the bed up with somebody else'.

After discussing the stresses of her life in nursing and the lack of time to be with patients when they needed support - aspects I return to discuss more fully in the next two chapters of my thesis – Isla said:

There is a patient at the moment – I would love to give her that [Therapeutic Touch] but I would have to get permission from the Consultant and Trusts and things...I actually thought it would be very helpful for this patient, and I hope it would give her some peace [...] I would love to have given that to the patient.

Here Isla seemed excited about being able to give the patient *some peace* which she identified as spiritual to be achieved by TT. At the same time she expressed lack of autonomy in decisions made about what was in the patient's best interest. This became a common theme amongst study participants and I return to it in the next two chapters.

Discussion

As we saw in Chapter One, early Hebrew man defined that which enlivened the human body simply as *ruah* which was 'breath'. However, later Greek philosophy and subsequent Christian theology considered debated spirit to be more than breath, as discussed by Plato. Similarly, in contemporary terms, energy could simply be the electrical charge carrying ions across muscle cell membranes to create movement, which science has demonstrated, rather than spiritual.

In telling me of her practice in using energy which she described as spiritual, Jane said *I could just feel the electricity* told me of her class experience with a Reiki practitioner, continuing that when she had practised Reiki on the teacher she *had really grounded her after it*. When I probed further into whether she equated energy with spirit she replied that it was interesting that we are *not aware of these energies* and that in Complementary Therapies *a lot of things are based on an energy thing*

Bach flower remedies and Reiki. However, we could go no further with her understanding of energy as spirit, or vice versa.

Summing up, so far, spirit could be anything from religious rituals and practices affecting toileting to therapeutic touch and energies. Are religious notions of spirit and spirituality the same as the contemporary? Ross et al conveyed ideas of spirit as transcendental and belonging to God who is transcendental to earthly bodily life. Contemporary views might be more akin to Bradshaw's claims. Or were they all non-spiritual but either masculine dualistic constructions after their projected God (Hampson 1996) in the case of Ross et al, and bodily experiences in the latter which had been given a non-material term to distinguish feelings from facts of biology?

This was an important line of enquiry for me. For nurses to practise specific spiritual care, it was necessary to understand what this was, and what it was nurses would be neglecting if they did not give spiritual care. According to the dominant discourse on spiritual care by nurses, led by Ross (1992) et al, which I discussed in Chapter One, spiritual care by nurses was essential to good nursing care. But in trying to find out why nurses should care for the spirit, it was necessary to understand what this nebulous concept was.

Spirit means uniqueness, essence, self, me

Similar to spirit as energy, the nurses often thought the 'spiritual' part of a person was what made them 'them' 'unique'.

The spirit as self or an individual's uniqueness was a commonly recurring theme, translated variously into 'person', 'essence' or 'me'. Joan thought the spirit was *the thing or essence that is me*. Agnes, who did not believe in any god for herself, said *I suppose the way I would define the sort of spiritual part of the person is the essence of the person, who they are*. The individual characteristics or attributes of a person, or even personal values, can be thought of as connecting with 'the source' or 'principle of life.' Those nurses who were training in CAMs specified the importance of harnessing the inner personal essence of the person specifically for healing. Joan described this well. She did not think of the spirit or spiritual part of a person as a

soul in a religious way, but as the self or their essence; it was more to do with the inner person, or who they were, and this, she thought, *was a great way of finding of healing of them [...] to let them grow and heal.*

Spirit as self

The spiritual part of a person was often described as the 'self'. Joan had

...a belief in self and that's not definable but it is something in me...I do believe there is something...the thing or essence that is me can be us, ...there is an element of me I define as 'I,' you know, who am I? Joan Brown - in Christianity it would be defined as spirit.

Mostly, this self as spirit was thought of as inner to the body, but occasionally the spirit was thought of as outside. Jackie described it as *the bit that protects you and your physical body is like the stone in the peach.*

Discussing how we could determine the spiritual aspect in people who lose their personal memory in dementia, Joan said:

I think that's where spirituality comes in, the idea of essence or self.

Isla said:

I think it's the uniqueness of them, uniqueness, something that em something that is [sighs] [pause] and I wouldn't say the uniqueness of the person is necessarily tied up with their illness.

She continued that with a patient who had memory loss due to dementia, *the essence of the person is still there we just have to find other ways.* For Joan working extensively with people with mental health problems she found that *If we can tap into that person* this helped as a nurse because

...when I work with people who are often very distressed and going through horrendous times - that little bit that is the, that essence is still there.

Eddie described how an elderly lady who was resident in the Nursing Home said her spiritual needs were time for her self, *time to be at one with herself* to be met through solitude and meditation. She *used 'spiritual'* related to her self, the need to *spend time on her own – this was her spiritual time used to go to go to the roof garden*. She voiced specific spiritual needs, though *she wasn't religious and that was the word she used*. Eddie commented that *I was quite amazed by that because she wasn't the sort of person I would have expected to do that kind of activity at all*. Yet the elderly lady in the Home spoke of her '*spiritual*' needs, though in non-religious, personal terms of the need for solitude.

But is the essence or self the same as the spirit understood by religious believers as soul? If the innermost self is the spiritual part of a person and is what makes a person uniquely 'them', what or who is the spirit? How, I wondered, was the self the spirit; how did the spirit/ual differ, if at all, from the psychological, social and physical characteristics which constitute a personal self? Isla said: *I've learnt a lot about myself - frightening at times! 'oh my god that's me', you do learn a lot about yourself*. Again as I discussed in Chapter One, Butler (1990 2000) in '*Gender Trouble*' argued that the self was in process. Rather than a pre-existing self, a person is themselves through 'doing' performances, rather than 'being' a pre-existent spirit or self. However normally when the self is discussed it is thought of as the person or personality not as the spirit, because the latter has religious connotations. I am recognisable as my self because of my face, body, name and personal history and so forth. Do I also have a spirit? If so, what is it? Where is it? And why does a nurse need to care for it? For Joan my questioning was answered by saying the spirit was the person:

I think you can be clear if you have embarked on the idea of spirituality as about a person and self in the chaos of people's distress.

As I discussed in Chapter One, there is overlap between definitions of the brain, mind and self as spirit, as well as personhood, personal identity and bio-psycho-social notions of the self. These impinge on our understanding of

...whether the nature and identity of the self [spirit] can be separated from contingent facts about concrete, social historical and physical circumstances, or whether such facts are fundamentally constitutive of the self. (Moody-Adams, 2000:255)

However, these contemporary ideas of the spirit as self seem different to the idea of a spirit superior to the bodily self which I discussed in Chapter One. It is important to have a clear idea of what it is nurses are being asked to care for if they are to give specific spiritual care in addition to psycho-socio physical care.

Spirit as self-discovering

Isla identified spirit as an exciting exploration of self which she thought was a spiritual odyssey:

...we are all self-discovering all the time, learning about ourselves all the time. I would say that it [spirituality] was that. It's difficult because everybody sees spirituality differently [...] we all have our own spirituality and I think we are exploring it the whole time.

Here Isla identified spirit with self and also how spirituality was effectively all things to all people. She also highlighted how the lack of clarity about the concept of spirit was demonstrated in the way it was variously described as spirit or self and continued that as *everybody sees spirituality differently* she is not sure if it is spiritual or not -*it's difficult to explain*. If as Isla believed, *we are all self-discovering all the time, learning about ourselves all the time* is this what Ross (1992 1997) et al meant by spiritual care?

When I asked Isla to tell me more about more about what she thought of as spiritual on the BSc Complementary Therapies course she was currently taking, she replied enthusiastically:

...uhm [pause]... you centre yourself and you're there in time but you're not – you're there physically but you're concentrating on self - and on the client whilst you're doing this or centred yourself, even.

Edie also thought spirituality was

...about self-discovering all the time, learning about ourselves all the time. I would say that it [spirituality] was that.

And likewise, as we saw earlier Joan said:

...the idea of a spirituality as about a person, and self [...] I have a belief in a self and that is not definable but it is something about being me and being whole within me - in Christianity it would be defined as a spirit.

Spirit as psyche or person

In Chapter One, I described the definitions of 'spirit' associated with mind as a non-self which is materially located in the brain. Separating it from material existence was said to be a creation of those who wish to believe in a spiritual domain. I explored this with the nurses to try to see how they thought spiritual care was additional to psycho-social care.

Joan, whose experience with the patient who self-harmed I discussed earlier, had extensive experience in nursing people with mental health problems, both in hospital and community, so I tried to probe further to see if she could tell me how, or if, she thought spirit differs from the inner self, psyche or mind. She said that in her experience *medicine for so long has you know separated out and said we're only interested in your physical signs and symptoms*. She thought the division of the person into both body and mind-spirit had been to the detriment of the care: *We've squashed it and under-estimated its power and I think it should be a core skill* even though she was unclear how this differed from the psyche. In her experience the spiritual aspect was described as

I say all that clap-trap about you know 'well it's all in your mind'. How many years has it taken us to move along well your mind has so much power over your physical body and equally you know I think your spirituality does too.

I thought Joan would be clearer about any differences between spirit and psyche than perhaps the other nurses who had not had this experience. She surprised me, then, when she said: *It would stand alone in that sense I would see it as more integrating...I mean I would [pause] it comes from my experience.*

She saw the spirit as *the triangle of your physical your emotional and your spiritual aspects*. Although Joan thought of the spirit as *very different I wouldn't have it in a list of physical, emotional, social, spiritual*, she nevertheless returned to saying she believed *it is a person* As well as being a person she thought the spirit

...was the thing or essence that is me can be us, can be harnessed and touched by physical, emotional, intellectual, and we get little insights of it and tap into the person.

However, she felt that where spiritual care by a nurse entered into nursing care was when

...their idea of self can be very low their understanding of their self may be almost gone in a sense cos they are caught up in the chaos that is going on and that you know how can they ever find me in this what I'm doing and things.

However, Joan stated clearly that whatever the spirit was, 'it' was separate from other identifiable personal characteristics. She also thought it integrated physical, emotional and social experiences:

It's working in the community you really see people as human beings...[you] see their full life and they are asking you just as much as they ask you to talk about their voices people open up about their self as a person and their self-esteem and all these sorts of things as a person. In hospital ...there are people who are so very very unwell that [...] I don't think they can articulate what they at all sometimes you need no sometimes they don't understand themselves.

Spirit as self-esteem

Joan demonstrated the complexities of caring for patients in the context of their whole life, which included social - their full life - pathological - their voices - and the person's self-esteem issues. However, as I have already discussed in earlier chapters, this was not the same sort of spirit Ross et al described as being transcendental to bodily or psycho-social need and which dominated the drive to have nurses include spiritual care. Indeed, it was the very opposite of what was envisaged since it was grounded in everyday socio-physical bodily life.

It was also noteworthy that she said it was easier to care for the whole person when in the person's normal living environment, rather than in hospital where they are so *very, very unwell*. Since hospital nursing was the context in which spiritual care giving by nurses is envisaged this, too, was an important factor in questioning why nurses were being asked to give spiritual care to patients. However the idea that the spirit or spiritual care of a patient was really the care of the person introduced ideas about what the person was.

Agnes, in telling me about her work in a very socially deprived area of a large city, said that many people had an *immense amount of spiritual poverty*. She went on to explain how this was related to deprived social conditions of high unemployment - *the daily grind of not having enough money* which resulted in poverty related to ill-health, high incidences of smoking, *having children very early on, sexual abuse, and so often they say they hate themselves*. Here Agnes saw spiritual care as affirming the individual's self worth:

Low self-esteem and that goes with a low spirit and a low sense of self and the essence of the self inside and I think their opportunities, their choices for developing the inner self are reduced in an area like that.

Here again, as with Joan, *self-esteem*, the *inner self* and the *essence* of the person were identified by Agnes as the spiritual part of person to be cared for. She later explained she thought of this self as more the outward, social face, whereas, she thought, being in touch with the spirit *you have to move to a deeper layer of the self and [pause] yeh*.

However, if the person, or personality, was the spiritual part of a person, then this raised significant difficulties with some patients. I wondered if the person affected by

dementing processes would have a spirit, separable from self, person and so on. Joan, however, who had also worked with people with dementia, described the spirit as different from the psychological memories which made an individual unique,

...and because you have lost your memory that's not you and again we're back to – for where I think spiritual for argument's sake, the idea of essence or self in that ehm if you see people...to hold their Mum's hand and have them respond and it's the first time they have responded in a long time and I think for some reason although other parts of the person are reduced see what I mean.

Here Joan illustrated well the slipperiness of the use of spirit and spiritual in the minds of nurses, as well as how this was important in nursing care:

I think that's where spirituality comes in, it is important in nursing, and in adult nursing, where you have people very distressed.

Even when memory had diminished beyond any reasonable recognition of the self of that individual person, Joan thought there was an essence which remained. She thought in her experience of working with dementia patients *we just have to find other ways*. Spiritual care was her way of tapping into *the essence of the person* which she said *is still there* even after the personality had disintegrated, as in dementias. It was this essence which she thought, from her experience, was cared for in spiritual care. In Joan's experience with dementia patients *people are not memory alone*.

Edie too had worked in psychiatry where she had trained in the early to mid-1980s and where she found *younger people used spiritual care as a comfort when they were distressed about symptoms*.

Discussion

It was unclear to me how Joan thought of her everyday nursing practice of sitting and how holding the mum's hand, for instance, differed from spiritual care. This experience typified what nursing research described as comforting in intimate closeness, or 'being with' and 'presence' as discussed in Chapter One. It seemed to

me that she thought the two were the same. Whilst for some study participants, the spiritual part of a person was separate from and apart from the psyche, even ‘out there,’ as for Joan above, nevertheless, it was largely unclear what the spirit was: separate from religious spirit or soul, or else the personal psyche or self. This suggested that ‘psyche’, ‘soul’ and ‘spirit’ might be the same phenomenon. If this were the case, it raised questions about whether spiritual care is different from, or integral with, other bodily experiences. It was unclear but then it was not often clear in either nursing or religious literature.

As we saw in Chapter One, however, Ross (1992) said that to consider the spiritual as synonymous with the psychological would be to neglect the need to help the patient find meaning in life. Long (1997) also suggested ‘self’ as ‘spirit,’ but then she suggested, along with Ross, that to understand how a patient thought or felt, a nurse had to care for the spirit, as well as physical, psychological, and social needs. Long clearly thought that the spirit was not part of ourselves since it was, to her, an unseen force or energy distinct from and transcendental to both human and earth body expressed as “...touching the untouchable and clasping the unseen...” (p.500). However, to Bradshaw (1994), nursing care appeared more earthed to human bodies one could both touch and see in the flesh, even if she perceived of such altruistic caring of a stranger as a form of spiritual service.

If the spirit is the self, as most of my study participants believed, and if this is a product of the biological brain in conjunction with the environment which dies with the biological death of the body, this is a very different understanding to that of Christian believers of an immaterial soul. It is also different therefore to the view of spirit as transcendental to bodily life as evident in the dominant discourse on spiritual care by nurses. If, on the other hand, nurses believe they are caring for the inner personal self as spirit, this is very different to caring for a spirit with ontological existence of its own, as believed by Ross and the majority of authors in the dominant discourse on spiritual care by nurses. I have already discussed aspects of this in relation to religious spiritualities gender and sexual identities (Chapter One).

To sum up, on the philosophical and scientific evidence so far, is there any reason for believing there is any real self other than the organic matter producing the mechanisms of feeling, thinking, smiling, and crying and so on? Moreover if the personal self is the spirit, as many of the participants in my study believed, then care of the spirit becomes the same as personal care. Of course when nurses care for the body they include emotional and psycho-social aspects of holistic care. But care of the spirit too? What was this? The person who becomes a patient is a “seamless whole” of body and mind (Edwards 2001:78). But was there also a ‘spirit’, which holds the physical, psychological and social aspects of human being together? This question is the root of the debate about why nurses should be expected to give spiritual care to patients. If the spiritual aspect is religious it is more appropriate for religious officials than for nurses, as usually the need is for religious/cultural practices which nurses would not be able to meet across all beliefs and non-beliefs in a pluralist and secular society. If the spirit, however, means ‘self’, ‘essence’, ‘energy’ or ‘person’, as nurses in my study said, then this raises questions as to what it is they are being asked to care for, and why. This was the continuing focus of my research.

The dying person or spirit

Whatever spirit was or was not, it was the issue of dying and death that brought it into focus. Almost all nurses in my study referred to dying and death as the reason that they had thought about spiritual issues. This was either in their personal lives or more frequently in nursing patients. *The dying side is difficult* as Dawn observed, whilst Judy said:

There are elements of spirituality, em, I think, [...], to do with death obviously, it's one of the few areas that kinds of flags that up in our modern society where people may actually want to address facing death, facing vulnerability, facing loss of, em, either their life, or, you know, a physical part of their body or whatever, that's where spirituality would address these areas.

Some nurses had a residual belief from earlier Christian teaching and practices. Eleanor equated the spiritual part of a person to a *goodness*, which she felt had to go somewhere after death:

Almost a goodness which has to go somewhere...I'm not a great believer in heaven and that sort of stuff but I do believe the spirits go somewhere and they remain watching over you – not guide you – but they are there.

Referring to her earlier Church of Scotland background, to which she no longer belonged in any external sense, remnants of earlier teachings appeared to me to linger in Edie's thought: *Yes yes there is a spirit which remains after somebody dies even though she acknowledged the idea of generations floating around somewhere - illogical when you think about it.*

Often, it was in describing their beliefs about what happened at or after death of a person that most enabled the nurses to express what they believed about the spiritual part of a person. Edie said *spiritual care to me is of someone who is dying, is last few days, it is making them comfortable.* This grounded the discussions in real nursing situations. Joan described this well:

You are thinking about dying as such and that brings in the whole question of spirituality and it is DYING it's not living and that kind of got me thinking as well in terms of focus...I don't think spiritual care is just about the patient dying it's just that is an immediate awareness it makes us think about spirituality.

Edie said of her experience in a Nursing Home in Care of the Elderly:

I have had patients who discussed with me what happens when you die and I am saying I don't know but families want to know.

However here she thought it was more the *process* of dying that was of central interest to families, such as *will they look different?* Often it was

The mechanics of what will happen when I die? What will it be like? What will happen to my body, my family? More to do with practicalities.

In Chapter One we saw how Copp (1999) found that nurses and patients experienced difficulty in talking of the body and the inner person as distinguishable when death was near. However she did not investigate spirit and body separation but spoke of the person separating from the body. Copp did use the word 'spiritual' but more in the context of the difficulties people have in resolving relational difficulties around times of death. This seems to be near to Bradshaw's view of spirituality as ethical and relational. Crowe (2000) raised the question of dissociation of a person's consciousness from the body and then, by extension, from another's body, in this case the nurse's. This could be what is happening in a dying person. As is suggested in the classic study by Menzies (1961), the nurse may also 'distance herself' from the vulnerability of a person who is dying. Crowe (2000) also found nurses distanced themselves in caring intimately for patients. Ross (1997), however, seemed to suggest natural death anxieties might be reduced by meeting spiritual need, though did not elaborate on this.

Many of the nurses in my study had a belief in a spiritual realm after death. Lilian said *I like to believe in sort of life after death.*

In this way the nurses reflected the conventional understanding that spirituality and religion were linked to dying or death, by nurses, patients and relatives. Lilian, who worked in acute care with patients who were sixteen to thirty five years old, said:

If you ask them if they are religious at all or if they want the chaplaincy⁶⁰ team to be involved they say 'I'm not going to die [laughter] and you know I try to say it's not about DYING it's about support while you are in hospital if you want it. If they see the chaplaincy team in the ward they think somebody is dying.

Joan said:

I do think there is something discernible that is me and I think you see that in terms the difference between me now, an alive, active individual, and me when the day comes when I am dead and something is missing

⁶⁰The National Health Service (NHS) since its inception in 1945 has recognised this in providing professional support for the spiritual needs of the terminally ill, dying and bereaved (DoH 1992) and these are valued by patients, relatives and staff.

there, and we all see that the person is no longer there, so I do believe there is something the thing or essence that is me.

Again there is overlap between the spirit, something *when I am dead and something is missing* and the person or essence.

One or two nurses spoke about beliefs which were Spiritualist⁶¹. Edie had a

sister-in-law who had died fairly young and her husband was um quite absorbed after she died and felt her presence strongly in the house for a number of days and went to spiritualism.

But when Edie's father had died she did not turn to spiritualism even though she, like her brother-in-law, had *felt the presence* of the recently deceased relative strongly. However this bereavement experience had made her *wonder* if there was a departed spirit as taught by prayers such as "May the souls of the faithful departed rest in peace" used in traditional Christianities. Although she had not pursued spiritualism she nevertheless said as a nurse she was *one of those old-fashioned nurses who opened the window to let the spirit out* [laughter]. She believed *she just had to do it* she had explained to *the younger nurses who used to ask me what I was doing*.

Lilian, too, who had told me *I like to believe in sort of life after death* believed there must be 'something' because a Spiritualist had conveyed messages to her Mum after her father had died. In exploring this further with Lilian, she replied, thoughtfully:

I do believe people can be contacted and people do have, can communicate with each other - from personal experience - my Dad died before I was born, and my Mum went along to some spiritualist [...] and they passed on a message and they knew things that nobody else could possibly have known [...] I often thought in the past they are definitely looking for something but in this case my Mum wasn't looking for anything – she had chummed her friend she deliberately didn't give any information away, sometimes people believe in these things cos their mind tricks them into believing there is something, in this case my Mum wasn't, my mother had never met this woman before-she was from

somewhere down in the south of England and this meeting was in Scotland so I think there must be something otherwise how would they know these things?

Whilst Lilian could not clarify what it was she thought the ‘something’ was, she nevertheless believed there had to be ‘something’ to explain the spiritualist knowing something about her Dad and his death.

Discussion

The point of importance here is that it is dying and death which is the impetus for thinking about spiritual concerns. This was interesting because it is argued that religion is a human construction to enable meaning to be made in an otherwise meaningless universe. Indeed, Bowker (1970) argued the reason religion exists at all is because men tried to make sense of suffering and to find ways both of preventing it and alleviating it. Amidst the pain of grief in dying, death and bereavement, human cultures over millennia have developed beliefs and rituals which enable humans to create order out of chaos. In time these rituals, such as rites and prayers for the dead, and those who practise them, are held to be sacred and set apart from everyday living and so become transcendent (Durkheim 1915). This can bring peace to people in times of crises. Marx famously called this belief the ‘opium of the people’ and ‘pie in the sky’ and declared it to be a false consciousness or ideology.

However, as we saw with feminist critiques of dualisms, an approach that accepts we will all die and that we are all part of the living material earth to which we will return can be as much a source of solace and comfort, if not more so, than being anxious or assured about facing a judging god and endless spiritual life or rebirths. Such anxieties presented in some of the accounts given by the nurses.

Dying soul or spirit?

Dying and death were thought to be much easier nurses with a strong sense of religious spirituality. Caitlyn, the nurse from the Caribbean, who was also a practising Christian, described nursing a patient who was in the terminal stages of dying with oesophageal varices:

He was very difficult to nurse. He was very clingy...he realised he wasn't going to live [...] The Sister asked me to speak with him so that could come to terms with the fact that he wasn't going to get better...decrease his anxiety [...] talk about how he felt.

Caitlyn also found spiritual needs easier to detect and to deal with though she also said this was because people in her home culture were mainly Christian. For instance, she described pre-death anxieties, as spiritual needs which she considered to be religious. She also perceived her role as facilitating these, provided the patient indicates need for this intervention. For example she said she would fetch the religious minister and be alert to the patient *saying things like 'How do you think God feels about me? 'Will I go to heaven or hell?'* It is a specific need, she thought.

Dying spirit or psyche?

However, unless the nurse or patient had specifically religious beliefs and needs, the nurses could not distinguish spiritual care of the dying from psycho-social aspects of nursing care of the dying. After discussing the dying and death of young adults whom she nursed, Lilian spoke softly, after another long thoughtful pause:

I dunno, I just dunno, I'm trying to put myself in that position because I don't know whether spiritual care would have helped me because I don't know what I believe I don't think it would.

Later in the conversation, still talking about whether patients expected nurses to give spiritual care, she mentioned what might be spiritual in care of dying patients:

*I don't think so I think, think they expect us to **listen**, but I don't think they expect - they look to us for comfort, especially in dying, they know you have seen a lot of people die. They look to us for comfort in that ...I wouldn't call that spirituality.*

Here Lilian portrayed her confusion over how she could identify spiritual care apart from “the care you just give.” In fact, she identified it with giving nursing care. Whilst Lilian identified *trying to make them as comfortable as possible* which was for a nurse *about sitting with them to talk if they want to express their fears*, she

nevertheless hesitated to identify spiritual care as being a help to them. She said *in my experience patients want to know what happens at death but who can tell them, none of us can, we all have different beliefs, none of us knows*. However, she did think there was more to life than material bodily existence but, when I probed this point later in our conversation, she laughed and said she didn't know what she believed any more.

Agnes also considered that :

Spiritual care is a part of care of nurses we give people I think it is important during sort of palliative care and also chronic illness is in some ways very similar experiencing to dying, also experiencing a great deal of loss, having to question their life, their values, looking back on their lives and relationships with others and refocusing so um as a nurse I think the spiritual care is um [thoughtfully, slowly, and softly] perhaps not formalised as such but just part of holistic care, I firmly believe it is. I think it can't be ignored when we care for people.

Agnes and Lilian here both talked about spiritual care of the dying in terms of giving comfort, helping the individual come to terms with loss, using communication skills such as listening competently to patients' questions about values in life, and the process of dying. These nurses demonstrated that spiritual care, to them, was holistic care. Such care has already long been part of good nursing: Virginia Henderson's (1966) famous definition of nursing was that nursing was to help the individual to perform those functions he or she would do for him or herself when well, or to enable a peaceful death.

Caitlyn also identified spiritual care with terminal care in subjects like loss and bereavement, especially in cancer care. She, too, talked about helping patients and relatives with loss through dying, death and bereavement. However, as a practising Christian, she also described religious and cultural practices as giving meaning and help to sick people, but she nevertheless did not articulate clearly how spirit/ual [care] was distinct from these.

In Jane's experience:

I mean I find that even in midwifery we have to give spiritual care to people that lose their babies and things like that.

And:

That lady that had lost her baby unexpectedly. I helped a younger girl who was looking after the lady and she said she felt guilty because she had her own baby and this woman had lost hers, so I felt I was giving spiritual care to her in order to help her come to terms with this.

Discussion

Listening to the story and concerns about failures and joys in life, past present and future, has long been recognised as part of the religious/spiritual care of the dying. It was not clear how Jane distinguished between this and her spiritual care of a bereaved patient, since she described more her comforting presence or being with and mutual support of a younger staff member as spiritual. She considered this to be her spiritual care.

Here, as so often, I wanted to bring different theories into our interview conversation, such as the more holistic feminist spiritualities considered in Chapter One. It would have been interesting to see how Jane and others responded to these ideas. It seemed to me she thought of 'being with' the lady, and giving comfort, as spiritual care, though as we saw in Chapter One, these are also the very features of nursing practice that are invisible or taken for granted and even considered to be 'natural' and not requiring any particular learnt knowledge. Here, the value of feminist perspectives on caring and spirituality enabled a deeper insight into study participants' descriptions of their nursing experiences.

Here also we talked of the role of chaplains especially in bereavement, whilst nurses and midwives attend to other needs. Usually the role of chaplains or clergy or other counsellors was to listen to the stories of individuals (Speck 1993). Walton (2002) also writes:

Whilst others are busy easing painful and distressing symptoms, the Chaplain has an evident role in creative listening to the story of a unique human soul. (p.3)

And within individual stories of patients told to or by nurses there are issues of trust and confidentiality. Jane for instance spoke of her experience in an antenatal clinic where a woman patient told her about being abused. Here, she illustrated the complexities and confusions of boundaries between whole person care and spiritual care. She identified the patient's needs as spiritual or at least she recounted her experience as evidence of patient's need for spiritual care, whilst she also struggled with how this may or may not be different to other needs: taking appropriate action about an abused woman would already be a nurse's role and not necessarily considered spiritual or religious, yet Jane told me about it as if it was part of spiritual care.

Reflecting on feminism and spiritualities in conversational contexts

Around the half-way mark of interviews I was trying to decide what was distinctively feminist about interviews and self-reflexivity throughout my study. I found that once my study was under way, it was not always apparent to me how or if feminist standpoint epistemology and feminist inspired theologies were relevant to my interview conversations. As Ramazanoglu and Holland (2002) observed:

Working out whether gender is a primary focus for a research project, a contributory factor or an area of contradiction may become a shifting area of decision during the course.

A note in my reflective diary confirmed this:

This was certainly my experience. I am continually concerned that I had the wrong methodology and that feminist approaches aren't applicable to what I'm hearing in interviews though there were times when I did think 'there is something going on here' but I think I will have to wait to look at the lot of them together. (13/12/03)

Nevertheless what was interesting was how the nurses persisted in the main in considering spirit as separate from the body, yet talked of caring for the person as a whole body and found it difficult to separate the two. I questioned how this would

affect their considerations of spiritual care as meaning, purpose and fulfilment in a transcendental way.

I realised also that as one of the community of knowers, like my study participants, I too was part of the culture which believed in spirit/body divisions and I too had nursed dying people and wondered what had happened to 'them'.

I was finding it difficult to see what was specifically feminist about my interview materials possibly because of the cultural absorption of dominant masculinist discourses so that perhaps I could not see it for what it was. However, I remained puzzled about why nurses should add specific spiritual care to bodily care. So far, it seemed to me nurses were describing nursing care as spiritual care, and this puzzled me.

Summary

In this chapter I have discussed what care of the spirit and spiritual care meant to practising, experienced nurses. It was difficult for them to describe, or define, the spiritual, which was understandable, since this was also the case in theoretical approaches to the concept as discussed in Chapter One. In a grounded theory sense, as interview materials emerged, I compared them with aspects of nursing theories, both within and between interview conversations. This process allowed the generation of newer understandings of what spiritual care by nurses was, and why nurses may be expected to give it to patients. Generally, the nurses thought the spirit was 'something' other than material life. Whilst religious understandings did arise, for the most part, contemporary notions of spirit were more commonly described as 'energy', 'essence', 'self', 'person' or even simply 'something'. It could mean ethical behaviour or therapeutic touch, more often than something transcendental to bodily life. From Caitlyn's traditional religious views of spirit as from the Christian God, to Jackie's *stone in the peach*, and a wide variety of beliefs in between these two extremes, study participants demonstrated the kaleidoscopic understandings of the spiritual aspects of a person existing in Britain at the beginning of the twenty first century.

It was not clear to me that the properties of the concepts of 'spirit' and 'spiritual care' described by the nurses were the same as the concepts derived from the theoretical literature on spiritual care by nurses. Indeed, the relevant theoretical literature described these categories as having very different constituent properties. Whereas Ross (1997) focused on more esoteric, transcendental notions of the spirit as giving MP&F, common to particularist Christianities (Hampson 1996), my study participants tended to describe it differently. This made it difficult to continue with the constant comparative method of the categories or concepts. The process of comparison of categories in the interview materials also led me to form the categories of 'spiritual care' as 'comforting, companionship and competence in communication'. This category, however, was different to that described in the dominant discourse advocating spiritual care by nurses, but was comparable to features of spiritual care described by Bradshaw (1994). Bradshaw's thesis was that nursing itself was spiritual and nurses did not need to add spiritual care if nursing was competent and compassionate (Bradshaw 1994 1997). This process of coding and constant comparison of categories and concepts nevertheless helped me to clarify the conversational materials under examination and feed into the discussion in the following two chapters.

In the next chapter I explore spirit and spiritual as meaning, purpose and fulfilment since this was the working definition in the dominant nursing discourse which I described in Chapter One.

CHAPTER FOUR

Meaning purpose and fulfilment

As we saw in Chapter One, conservative Christian or related religious views entail belief in a God who is spiritual, real and transcendental to everyday life on earth. On this view, meaning purpose and fulfilment is said to transcend bodily experiences of life (Ross 1995 1997 1998). Indeed, Ross (1997) defined the spirit as “that which gives real meaning” (p.8); which “is not bound by the same natural laws as the body” (p.183) and is

...the part which gives meaning and purpose in existence; which strives for transcendence beyond the here and now in search of some higher being e.g. God (as defined by the individual), something greater than self. (p.8)

The basis for this claim is mainly drawn from conservative, Christian interpretations of the Bible and subjective, personal experience evidenced when Ross (1997) discussed hope and faith in God as significant in

...numerous instances of miraculous events e.g. healing of the deaf and blind, raising of the dead where hope and faith in God were central [...] These instances are hardly surprising if, as McGhee (1984) states, the degree of hope is related to the perception of the individual with regard to what is desired as probable. The bigger one's conception of God, the more things become possible and obtainable. (p.18-19)

Universal biological need for spiritual meaning, purpose and fulfilment

Ross said that the spiritual is a universal dimension going beyond religion, as well as everyday living experiences:

...in search of ultimate meaning purpose and fulfilment in existence the spiritual dimension pervades all other dimensions and life stages, allowing for transcendence beyond the ordinary to the extra-ordinary and mystical, thus adding a new dimension to daily living. (p.10)

Several other nursing authors, agreeing with Ross, also defined spirituality as a search for meaning beyond bodily experiences, such as hope in God or a Higher Being (Narayanasamy 1991 1999, Reed 1992, Harrison & Burnard 1993, Dyson, Cobb & Forman 1997, Greenstreet 1999). Narayanasamy (1999) developed a view of the spiritual as biological, universal, human need for meaning, purpose and fulfilment as important for human survival. Burnard (1987) believed that: "...spiritual distress is the result of total inability to invest life with meaning." (p.377)

Yet despite claiming that meaning purpose and fulfilment is a spiritual need going beyond bodily life, these authors claim that the need is biological. This was based on empirical research of a committed evolutionist (Hardy 1979 in Narayanasamy 1999) and a classic work on the numinosity of the spiritual and God (Otto 1950). To Narayanasamy (1999), spirituality is believed to belong to everybody by virtue of their biology as humans, who are only able to find meaning in their lives if united with the metaphysical transcendent God or Ultimate reality "...or whatever an individual values as supreme." (p.274). these authors, then, argued that the spiritual need for meaning goes beyond religion, as well as everyday living experiences.

It is in this area of the imperative of spiritual care by nurses that the dualistic hierarchies of spirit/matter and body/soul became apparent in the dominant discourse advocating spiritual care by nurses. Narayanasamy (1999) claimed the peace that is derived from belief in transcendental spirituality is a specific characteristic of "...those committed to religious world outlook...", whilst conceding that non-believers in such a dualistic universe may have "...something of the serenity and inward peace." (p.278)

Meaning and purpose are considered important for recovery or a peaceful death, in accordance with Henderson's definition of nursing (Henderson 1977 in Ross, 1997). Finding meaning is thought to reduce emptiness and despair and is said to be important for ego-identity in psychological theories. Ross thought meaning, purpose and fulfilment was important since it is identified that, in the Jewish concentration camps, for example, those who had purpose and meaning in life survived better than those who did not (Frankl 1959, in Ross 1997).

Meaning purpose and fulfilment in healing

The central need of meaning has been seen as a necessity for spiritual care of patients by health workers. Scott-Murray (2002) reported that a study funded by the Scottish Executive (2002) found General Practitioners (GPs) to have recognised that patients saw spiritual care as important though they found it difficult to raise it as an issue, and hoped that nurses or doctors would do this for them. This, however, seems contrary to other studies where patients said they considered caring, competence and comforting skills to be 'spiritual' care by a nurse, as discussed in Chapter One. Similarly, studies discussed already located meaning within bodily memory and bio-psycho-social realms, so not everyone thinks of finding meaning in a pseudo-religious 'other-worldly' spiritual way. (Venning (2003) depicts a woman lounging over a chair saying to her male partner, sprawled on the sofa:

No Brian I'm not trying to negate the feelings you've expressed. It's just that this time last year you thought that you were suffering from existential despair at the meaninglessness of existence and that turned out to be the end of the football season. (p.28)

The notion of meaning as being experienced in terms of physical bodily and social relationships is discussed by Flemming (1997). She described people as finding meaning in seeing the family grow up or in terms of successful treatment and a new drug which would

...get rid of the cancer in everybody's body. My one hope is that it won't get any worse...keep the tumour down [...] live a little longer [...] without pain.(p.17)

Lorde (1988) wrote that her main concern when she was diagnosed with breast cancer was when to tell her family, who were in final years at college and how, for herself, it was not possible to make sense of life as there was none, so she could only respond to life as she was experiencing it, rather than see it as a problem to be solved.

As already discussed in Chapter One, restoring bodily function through improved muscle tone post-stroke was experienced in a whole body way, and Doolittle (1990)

also found that stroke patients found meaning in restoring their pre-stroke social lives; it was this in which fulfilment was found, and no mention is made of finding meaning purpose and fulfilment outside of their social worlds.

Discussion

As well as their own beliefs in a dualistic universe, the authors in the dominant discourse on spiritual care by nurses base much of their argument for meaning, purpose and fulfilment on the claim by Frankl (1959) that many of those who survived the Holocaust did so because they had meaning, purpose and fulfilment. However, for many other survivors this was not the case. Sixty years on, stories from survivors participating in the Auschwitz Music Memorial Concert described their meaning, purpose and fulfilment more in terms of having some food and not being beaten or killed. One unnamed sixteen year old girl had left inscribed on the wall of her cell: “There’s nothing to eat/ Not even a crust/And the guard is evil/He beats us everyday,” adding “Mother do not cry” (BBC2, 21/01/05).

Or, less poetically, in her down to earth way, cellist Anita Lasker Wallfisch said: “When the only way to freedom was through the smoke of the chimney” it was playing music, even to the Nazis that gave “...some spiritual escape in your head, because “...music is the most appropriate form of reconciling us to human suffering.”

If such an abstract term as meaning, purpose and fulfilment had any meaning under such horrific conditions, holocaust victims speak of finding meaning purpose and fulfilment in relationships with their earthly loved ones, as ninety four year old Leon Greenman poignantly expressed it: “I didn’t know my wife and son were gassed within hours [of arrival at the camp]. I told myself I would find them. The thought that I would keep me going”.

The themes of physical survival and physical escape during the long years of imprisonment were taken up also by Maria Ossowski, one of the estimated one thousand and forty thousand non-Jewish Poles imprisoned at Auschwitz:

But you couldn’t ask why this was happening. There was no answer. If you start asking such a question, you start asking, where is the God?

Sometimes you did ask where the God was, but then sometimes you needed him on your side. (*The Guardian* G2 2005:8)

If spiritual care is defined as meaning, purpose and fulfilment as argued in the dominant literature, on the basis that spiritual meaning purpose and fulfilment was what enabled survival in the Nazi concentration camps, as the most extreme suffering imaginable to many, the evidence is that they did not perceive of meaning purpose and fulfilment in spiritual terms, except possibly when this was in music – which was a means of survival – or in being physically reunited with their loved ones. One can conclude that authors who define spiritual care as meaning purpose and fulfilment do so, because, they argue, it helped people survive the holocaust, this appears be a seriously flawed argument.

Nurses and spiritual care as meaning purpose and fulfilment

Despite the difficulty of finding a consensus about what spirituality is in our society, most of the nursing literature, nevertheless, following Ross, advocates that nurses should be educated to give spiritual care defined as meaning, purpose and fulfilment because of its pre-eminent importance to patients. To enable a patient to find such meaning, nurses, it is argued, should be educated to assess a patient's spiritual need and to implement and evaluate care given to meet these needs. Since spiritual care is defined in the dominant nursing literature as finding meaning, purpose and fulfilment and said to transcend physical and psycho-social life, I went on to ask the nurses if they had experience of helping a patient meaning, purpose and fulfilment and, if so, how. I then developed the probe question to ask if they thought helping a patient find meaning purpose and fulfilment was the nurse's role and, if so, how. Another probe question explored whether, in their experience, they felt nursing care was less than good, or even that they may have failed their patients, if they were not able to help with issues of meaning, purpose and fulfilment. However these questions and probes were not consistent or linear within or between interviews. As with describing their understandings of spirit and spiritual, it was often in the context of making sense of

suffering, loss and, especially dying, that nurses discussed awareness of meaning, purpose and fulfilment issues.

Don't know where I'd even begin

The dominant discourse on spiritual care by nurses may argue that helping patients with meaning, purpose and fulfilment is essential, but the nurses in my study demonstrated this was not how they experienced it, indeed they recoiled from it. They all appeared to assume that meaning, purpose and fulfilment was to do more with existential and suffering issues. Lilian exclaimed:

See I don't know. I find it difficult to find sense in suffering I don't know how I'd even BEGIN to help patients find sense in it.

Edna expressed very forcibly, and with anxiety, the many concerns there are about nurses helping patients with meaning, purpose and fulfilment. Firstly she identified the complexity of the issues involved in meaning and asked if it was ethical to impose such a practice as seeking MP&F on a patient who was suffering and or dying. Since this is the commonly agreed definition of spiritual care in nursing it is very important to my study to discuss whether nurses' roles should include this. Isla spoke strongly about not being able to say what meaning for any individual is and implied that even if the meaning was discernible, it would be unthinkable to load this on the patient who was suffering enough already.

If you're saying a meaning to this is they're here because they've done x, y & z if they're suffering because they've done x y & z well they're not, they're not I mean god knows why they've got let's say it's cancer god knows why it is not because...

The anxiety that patients may feel or wish to discuss with a nurse, *that they have deserved it or anything*, was the root of this nurse's anxiety based in caring for people across a wide spectrum of nursing experience. We went on to talk a little about the ethical dilemmas inherent in helping a person with meaning, purpose and fulfilment. There are complex issues in nursing patients where questions of morality may arise. Patients may perceive that they have acted immorally, or that others may

consider this to be the case; or perhaps the nurse may feel this if she has conservative religious beliefs about sexualities., or other morally laden diseases Edna felt that for nurses to try to help a patient with meaning, purpose and fulfilment if the person in may be dying of HIV /AIDS, for instance this would be to cross professional boundaries and potentially make it more difficult for the nurse to practice unconditional acceptance in accordance with the professional Code of Conduct (NMC 2004).

Moirra considered helping a patient with meaning, purpose and fulfilment to be incorporated into ensuring the well-being of the children with learning disabilities with whom she worked. I asked her if patients or clients would know what was meant by meaning purpose and fulfilment. She said:

It is difficult in learning disabilities as the people don't bother about that do they - they are happy just trusting you to do what they need...They wouldn't understand meaning, purpose and fulfilment I don't think, I mean how would you DO it?!

Even if nurses were taught to give spiritual care as helping with meaning, purpose and fulfilment issues, however, there were foreseen difficulties. Lilian said *I can get all the teaching in the world but I am still not going to be making any sense of it.* In addition, there was the added conflict between what a nurse may believe or not and what she may have to help a patient with; as Lilian said: *you know teaching me about it doesn't mean I am not going to believe it.*

These personal and professional dilemmas were related in their experiences, as Lilian found:

...especially when you're dealing with young people I found in deaths I encountered, I found it much easier with older people than with younger people but I am not sure,

Here my research approach of being a part of the community of knowers, where it was 'us' rather than 'them' and 'me,' was evident. Hopefully I was able to show, by my facial expression, tone of voice, and non-verbal gestures, that I empathised with such painful situations, that I also had found similar experiences difficult, and was

open to their experiences and reflections, so encouraging them to talk more. Sometimes, however, I did say something specific such as “yes it is difficult isn’t it?” drawing on memories of my own experiences. I could not envisage myself ever having any inner resources to help with the meaning(s) of the deaths of young people I had nursed. Their deaths seemed pointless to me even as a practising Christian, as I was then.

Edna said the idea of helping a patient find meaning purpose and fulfilment made her feel physically sick. She referred to my letter introducing the research study (see Appendix) in which I had written “...there’s a lot of contentious theoretical stuff about which says that nurses should help patients find meaning purpose and fulfilment”. She went on to describe how when she read that *it just, I went, ‘oh God’ it made me feel quite sick actually*. Our conversation started from there because she seemed so shaken when we started the interview that I had offered to stop it. However, she agreed to continue. But it was obvious that she was so distressed by the prospect of spiritual care as being about nurses helping patients with meaning, purpose and fulfilment that she had nearly not come to the interview. I had to be very gentle and thoughtful in my approach with Edna and asked her to talk about why she felt so upset. She replied:

... ‘should help patients find MEANING’, I think it’s that bit about finding meaning in their experiences of illness and dying I think nurses yes there to support the person in illness and dying but I dunno if it’s something about finding

um tell me a bit more about that cos we’ll come back to that – why do you think that?

[sighs] it’s almost not about being a nurse here I think I am speaking more about being a person like, somebody that’s dying, somebody that’s suffering, it could be looked upon, you know, I don’t firmly believe that, as I say I’m speaking as a person I don’t know about this finding meaning I think illness and dying, I dunno, I just find it heavy and I think it would be very very difficult to I think, yes. To be given the background and the basis in order to understand spirituality, as a starting point I mean you know, hospital [...] [...] I have been in hospital myself as a patient four years ago and I had a lot of support from the staff and I had support from the chaplain was round as well and I had a lot of support from the chaplain too but to put it in perspective, when you think of everything else nurses and midwives do then it’s the TIME aspect.

Like Edna and Moira above, Judy, a practising Christian, who already had considerable doubts about what spirituality meant, comparing it to trying to define madness, and was already sceptical about nurses meeting spiritual need, had serious concerns about nurses helping with meaning, purpose and fulfilment. She expressed dismay and experience of being *dumbfounded* with the impending death of a forty three year old man with pancreatic carcinoma and questioned if patients would expect a nurse to help with spiritual aspects of meaning, purpose and fulfilment any more than the nurse would expect to do so:

I said before the expectation of patients you know I'm a nurse they're a patient they're in hospital to get fixed - [pause - longish] I think it's an areas which in our multicultural multifaith secular society is difficult to map isn't it?

To give spiritual care defined as meaning, purpose and fulfilment, she said...*the phrase 'helping people to find' [meaning, purpose and fulfilment] is ringing alarm bells for me - what tools would you use?* I explained that people like Stoll (1978) have tools, comparable to an emotional well-being check-list for spiritual well-being, asking the patient directly and observing if they have a Bible on their locker and so forth. Judy replied *uhm these would be religious though wouldn't they? Rather than spiritual, the examples you use.* However, as I explained, since 70-80% of the population do not have any affiliation to any religion the idea is that these people nevertheless have spiritual needs in terms of finding meaning, purpose and fulfilment, linking in with something greater than them, or however else this might be understood. I asked Judy if she found she had ever done that in her experience as a nurse:

Phew [pause] well! If somebody's come in to get an ingrown toe-nail taken off then I would have thought that wasn't a context, wasn't appropriate to help with meaning, purpose and fulfilment my role as a nurse is to make sure the patient doesn't suffer in the process.

Many nurses also felt meaning and purpose was such an individual thing that they felt unable to deal with it in any meaningful way. However, where the patient had a

religious faith then nurses saw their role as involving the appropriate faith representative.

Time talk and teamwork

As well as qualifications, or lack of, to help people with meaning, purpose and fulfilment, the nurses were also concerned about the amount of time required to deal adequately with such complex issues. Lack of knowledge about such matters was another concern. Moira mentioned lack of suitably knowledgeable staff, since:

Whys are difficult to deal with I mean how would you DO it? and lack of time, but that takes a lot of time and nurses don't have a lot of time.

Edna who was very anxious about even the prospect of a nurse being involved in meaning, purpose and fulfilment issues, said:

I think to be trying to find meaning, in the illness is something else, and I don't know it would take years to do I don't think in a nurse's training.

She also mentioned the importance of quality time to give the patient the quality of care required:

These things take time and it's very difficult to work that into your working day and people that need that time don't want to be short measured they need quality time.

Time also featured with Moira from the point of view that nurses did not have the time required to deal with meaning, purpose and fulfilment matters:

Big Questions like why has this happened to me? It needs a lot of knowledge and time does a nurse have that amount of time?

Isla said that pressures of work precluded being able to fulfil patients' need for finding meaning, purpose and fulfilment:

...if that's what they're needing you should be there to fulfil and to help but you're always thinking 'oh my god I've got this to do and lunch is coming up you know there's always something else needing done - time management skills [laughs] I mean how do you put down on paper 'Oh well I had to spend that amount of time with so and so because I felt that was what he needed?'

Edna said she had personally found the chaplain helpful when she had been a patient, commenting *that chaplain had a lot of experience as well ehm and a lot of training to do what she was doing*. By contrast, she thought nurses had neither the professional expertise nor the time, views which I shared and have discussed elsewhere (Grosvenor 2000).

Moirá had similar concerns: *Am not sure the nurse is the best person for spiritual care*. She also expressed concerns about the ethics of nurses helping patients with meaning, purpose and fulfilment: *Is it right, ethical even, for nurses to give spiritual caring how can they know enough to help patients with meaning, purpose and fulfilment?*

Agnes also questioned if such complex issues should be part of a nurse's role. She said that

If it was a meaning of life thing it would have to go to the minister the person wanted um [pause] I mean who is qualified to speak to somebody about what their life has meant and what is the meaning of life I am not sure it is possible to be trained into or educated to help someone, I mean you can help someone make sense of their illness you can help with changes, loss of function but the meaning of life I am not so sure both actually [laughter].

Here the nurses demonstrated the difficulties of separating physical meaning from bodily experience as discussed in Chapter One. If there was any transcendental meaning, they felt strongly that nurses had neither the time nor the professional ability to deal with such complexities. This created further questioning in me about nurses giving spiritual care perceived as transcendental to bodily life.

Often for nurses trying to alleviate physical or psycho-social distress was demanding enough, as Dawn, who worked with people who had rheumatoid arthritis (RA) and other related chronic painful bodily conditions, said. She had difficulty understanding

how a nurse can help a person with meaning, purpose and fulfilment *when they can't get comfortable and are in pain*, when it was *difficult to think straight*.

Meaning purpose and fulfilment in dying, suffering and loss

Although some nurses thought it was not a nurse's role because of the complexities of life and death issues involved, others thought that finding meaning, purpose and fulfilment was necessary. However, this related more to support, information giving, and allaying anxieties about the dying process Jackie's experience in twenty-five years of paediatric nursing was that: ... *it was much more about saying to people where are you going to get support from and what kind of support is it you need and what will help?*

However where both patients and nurses had religious belief, spiritual care as meaning, purpose and fulfilment was considered part of nursing practice. Caitlyn said *people open up about how they feel about dependency and life and dying and their suffering*.

Religious soul in meaning purpose and fulfilment in dying

Lilian said *nurses with a strong religious belief found it a lot easier to find sense and meaning in things*. This seems understandable in a Christian culture where spirituality and meaning is connected with the soul, life after death and God. Use of the religious and philosophical notions of spirit as an immortal soul could be helpful to a nurse in helping a patient with spirituality as meaning, purpose and fulfilment. Jackie, one of the three Christian believers in my study, thought religious words and ideas gave helpful tools for talking about difficult experiences with patients:

...soul for want of better word, you know the thing that makes you you, keeps going [after death] so that they can hang onto that in terms of you know the body isn't working properly but it's really just a case, the shell or house that you live in that makes you you, um, doesn't need that any more um, and it goes somewhere else and depending on what they believe of think um then you can say well you don't lose it, nobody can take that away from you, the only bit that's gone away is the house ...you don't lose the soul nobody can take that away from you so that means it can, it

makes a framework...and you can tweak it depending on what people think it's a picture of how you can separate it into bits that are manageable it gives you a framework to keep going really.

In the extract above, from my conversation with Jackie, several interesting and interrelated issues arose. One was the religious⁶² and philosophical idea of the physical body as a shell, or house, for the soul or spirit. Jackie was herself a practising Christian although she had wide experience of other faiths since she had lived in many different countries as a child and worked in London in her twenty years of nursing practice. Her faith was more of the liberal, ethical, practical tradition of Methodism, rather than the more esoteric, 'other-worldly' traditions as mostly evident in the literature recommending spiritual care of nurses which I discussed in Chapter One. Nevertheless, her ideas included conventional Christian spirit/ body dualism. In her work as a nurse she drew on this to offer what she called *a framework* of meaning to those patients who were dying, especially:

...young people who have their life planned and it's taken away from them and they go through all these things you know 'what have I done? I'm not a bad person.' All those sorts of issues, uhm, you know, 'Is it something I've deserved? 'I'm frightened what's going to happen' uhm questions - you've got children facing losing a sibling or a parent or somebody close to them and finding a way for them to discuss in terms they can understand. I remember talking about your 'soul' for want of a better word.

Jackie said however that patients felt this sort of discussion was more appropriate for ministers of religion and hospital chaplains.

Lilian worked with young adults who had cystic fibrosis, some of whom died young. She also questioned if a nurse had the time and also the ability to help patients with meaning, purpose and fulfilment issues:

⁶² In monotheistic traditions such as Judaism, Christianity and Islam the spirit is generally believed to be individual and given by the transcendental spiritual God, who judges whether the disembodied soul will return to live for ever with Him or be punished to eternal damnation in Hell after death. There is the theological dispute about whether this happens at the time of death or at the time of the resurrection of the dead which the apostle Paul, the Jewish convert to Christianity preached (1Cor 15).

A lot of people are seeking to find meaning in their illness, meaning in their dying but I am not sure it is nurses alone it's multidisciplinary team you know I think lots of people are involved.

For those nurses and patients with a strong religious understanding of spirituality however, meaning, purpose and fulfilment was clearer. Caitlyn, herself a Christian and active church member, spoke of nursing at home in the Caribbean

where patients...would often go up to a nurse about what was happening to them...help them make sense of it...when they were facing dying and dependency...We used to help the patient try to make sense of what was happening, maybe to give them peace to die or to accept their diagnosis.

Of all my study participants, Caitlyn's views about the nature of the spiritual in enabling a person to find meaning, purpose and fulfilment was closest to that in the dominant discourse advocating that nurses give spiritual care to patients. She herself believed in the power of prayer, God and the Bible for giving meaning, purpose and fulfilment in life, illness and dying. Indeed, that she believed this was often more important than scientific medicine was demonstrated when she compared nursing in Scotland with her home, she said:

I think because people rely more on scientific medicine to get them better but sometimes I don't think that is what is needed, for instance they may go to the doctor when what they need is to go to church or read the Bible to give them meaning, purpose in their life...medicines can't cure everything.

Judy, who had described herself as *a practising Christian in inverted commas* said thoughtfully:

Many nurses find themselves in circumstances that are bigger than that [spiritual care as meaning purpose and fulfilment] so often in care of the elderly you're dealing with people at the end of their life so they may be reflecting on what has happened in their life regretting or what they have achieved that they are happy with, or they may be - though people don't often articulate it - may be concerned about the future, the process of dying first.

Judy highlighted the complexities of the nursing care situations in which sensitivity to the plight of another has an impact on the nurse who struggles to cope:

When I was in module there my first medical ward I went up and spoke to this man he was in his mid-forties and he said 'I've just been diagnosed with pancreatic cancer and I've got three weeks to live. I was completely dumbfounded, discomforted, what could I say? So as a nurse in those circumstances and some framework of sensitivity might include some sort of spiritual assessment too [sighs] as a nurse [long pause] yeh I am having difficulties with -

The impact of the perceived suffering experiences of another human confronted this inexperienced nurse with the stark reality that there was nothing that could be said. *I was completely dumbfounded, discomforted, what could I say?* Given that the nurse had been a mature entrant to nursing and was a Christian believer, the depth of feeling of this response was, I thought, significant as she struggled to consider how she could help the patient with meaning, purpose and fulfilment.

Judy was unusual, however, as usually it is religious nurses who have clearer ideas and beliefs about meaning, purpose and fulfilment issues in life, as evidenced by the literature on the topic, as well as by the views of the nurses in my study. Supposing, Judy conjectured, *I say 'I believe this is all there is' I am perfectly entitled to hold this view* [that there is no spiritual survival of the spirit-soul beyond the death of the body] how, under such circumstances, would a nurse give spiritual care defined as meaning, purpose and fulfilment transcendental to bodily life?

Rather than spiritual care as meaning, purpose and fulfilment, Judy felt that knowledge of support and grief processes⁶³, as well as nursing skills to make the patients' last few weeks of life more comfortable, was what she expected to use as a nurse. This nurse also felt that rather than spiritual care, knowledge of the dying and grief processes might help with the care of the patient:

I don't know if I would use the term 'spiritual' apply the term 'spirituality' to it if I had a better understanding of how people might

⁶³ These are part of nursing preparation and practice.

react in those circumstances, the shock, anger, denial psychological stuff
[pause].

I returned to the topic of the man with carcinoma of the pancreas to ask Judy if she thought that knowledge of supposed spiritual aspects of that experience of terminal illness, diagnosis and loss, would have helped to nurse the patient better, as Ross et al claimed. She pondered: *...did the man think he had spiritual needs, would he have described it as such?* She could not see how her own faith would help anyone else *... if he isn't prepared to use that terminology* and felt that as a nurse the professional duty of care lay in being sensitive to the patient's needs, *... it was appropriate to be sensitive to the issues he had,...* whatever these were. It could only be imagined that these would be negative in the face of the diagnosis and short life expectancy. How would belief in a spiritual heaven help the patient feel his life and premature death were more meaningful, purposeful and fulfilling? In trying to help a patient with three weeks to live, Judy asked:

What right have I to impose that on him, form a nursing philosophy that none of us have necessarily signed up to, or agreed. I mean what if I am sceptic an atheist, how do I deal with this?

Judy's humour and pathos illustrated well the complex dilemmas a nurse might confront with meaning, purpose and fulfilment:

If somebody was a Calvinist in the Highlands and he believed he had been predestined to Hell then M&P might mean agreeing with him 'yes I can see where you are coming from you are predestined to Hell there is nothing you can do about it I am not sure what comfort I can bring you at all, other than make what little time you have left here as comfortable as possible, but knowing that you're going to hell so...'

Lilian was also worried and asked:

...if you are not even sure of your own spirituality how can you help patients find meaning in their illness and dying so to help patients try to find meaning, I think it would be quite difficult...

When I probed to see how or if Lilian understood spiritual care as meaning, purpose and fulfilment she said:

Oh oh [thoughtful silence] I don't know, [very quietly] it's such a difficult thing to put into words the care you just GIVE to the patients to the palliative patient you obviously don't want them to be distressed, you're trying to make them as comfortable as possible and that is not always about medications and it's about sitting with them to talk if they want to express their fears and not to say nurses can help them, you can't always help them find a meaning, but you can certainly LISTEN - a lot of the patients I work with die young, they go out fighting - I don't think spiritual care would have helped.

It was such a difficult thing to put into words had very close resonances with the invisibility of bodily and emotional care identified as feminine or women's subjugated knowledge in Chapters One and Two. Here I saw the benefit of feminist approaches to my study where care that was said to help with meaning, purpose and fulfilment was not other-worldly, transcendental spirituality but grounded in the bodily presence of the nurse: *It's about sitting with them to talk if they want to express their fears and not to say nurses can help them.* Additionally it was about specific nursing skills and knowledge: *... you obviously don't want them to be distressed, you're trying to make them as comfortable as possible and that is not always about medications...*

I have already described in Chapter One how patients' expectations of nurses or doctors are to do with being there as a comfort (e.g. Stiles 1990, Clarke 1991).

Despite evidence that what patients want from nurses is comfort and care as well as technical competence communicated kindly, Ross et al continue to argue that what patients need is for nurses to give them spiritual care defined as meaning, purpose and fulfilment beyond ordinary physical life.

Meaning purpose and fulfilment in relationships

Ross mentioned that meaning is, or can be, invested in bodily roles and relationships, and a measurement of personal well-being is cited (Renetzky 1979 in Ross 1997). Ross implied but did not spell out that this meaning, purpose and fulfilment was

vested in mundane earthly matters rather than any transcendental meaning or purpose.

The nurses in my study frequently found relationships painful experiences with both colleagues and patients. Joan thought, in her experience with people with mental health problems, that as a nurse it was where there were relational difficulties that meaning, purpose and fulfilment came to the fore, and that *...where you end up with discord is where you think you have no meaning or purpose or no - maybe as an individual you do reach that.*

Equally, there are those nurses who 'cope' by putting up a barrier As Lilian said, there were some nurses

...who were very good at their job as technicians but didn't talk with or get involved with the patients, didn't talk with the patients as much...it doesn't upset them. But I think if they aren't getting involved with the patient then maybe you're letting the patients down and failing the patient... often late at night ...when all is quiet and calm, that's when they jump on the opportunity to talk.

But Lilian emphatically did not think it was her role as a nurse to be involved in *finding the meaning in life or dying or something*, even though she did personally believe there was more to life than bodily existence. She described how younger patients [with cystic fibrosis] in a hospice

...who were in the unit for a long extended time ...built up very close relationships with the nursing staff, and a lot of nurses found it so painful to listen cos they didn't want [the young patient] to go,[die] especially a lot of the nurses who had maybe worked there for ten years or so cos she had come from [Sick Children's Hospital] at age of sixteen and they had seen her grow up, - she died when she was twenty-seven - she was quite poorly as an adult - so it was very difficult.

In a way it is almost like family isn't it?

Yes it is and you do become friends I still keep in touch with some of the patients.

...maybe the nurse isn't the best person to give possible spiritual care cos she is like family sometimes, is with the patient so long?

Yes twelve hours a day thirty seven and half hours a week and more if you do extra!

Here Lilian pointed up how intimate caring for another has an impact on the nurse due to the close relationship that builds up over length of time and proximity to the person's suffering, as I discussed in Chapter One. I tried to probe whether this meant the nurse perhaps was not the best person to help with meaning, purpose and fulfilment issues since, in my experience, some distance rather than being part of the person's personal story is helpful and even necessary. Lilian said:

Yeh you do get the why questions, but I don't know the answers. I can help them explore by talking, but I can't provide the answer I don't think anybody can...I don't know why they were born with the disease and are going to struggle all their lives.

Here we talked about the meaning of the illness being scientific so any transcendental spiritual meaning, purpose and fulfilment would be inappropriate, even if possible to ascertain - ...*if there is one which I don't know if there is.*

As we discussed the role of the nurse in spiritual care defined as meaning, purpose and fulfilment, Dawn asked me rhetorically:

There are so many social aspects to relationships and patients' lives that give meaning purpose and fulfilment – how can nurses help with that?

These relationships are between the nurse and patients and the patient and respective families and significant others, such as friends. As Agnes said, in her experience:

..if they are frightened or if they have a faith or what is supporting them but I don't ask direct questions about the meaning of life though if hopefully through the relationship I have built up – if a person wants to share parts of their life how comfortable they feel with that, the things they had done with their family and so on, you get a sense of how a person views their life, who they are, the spirit within that person I guess, so it's a case of knowing the person.

Deidre graphically described how if a person feels unloved, unwanted and uncared for by anyone then living may have no purpose. She said when working in an acute medical ward:

*I went to help the student nurse put Mr X - 'Jummy' - into the bath, since he was his usual obstinate, miserable self, refusing to budge from his bed of incontinent faeces mixed with his toast – lovely !- and she was having trouble with him as we always did. 'Get away from me leave me alone or ah'll put this in yer ****' he said and I tried to be patient - we had this EVERY day! - and say 'you can't say that to the student nurse Jummy she's a young lady you know' but he kept looking down and hung onto his jama jacket and top sheet. Eventually, after much persuasion into a bath telling him how much better he would feel etc etc when we were trying then to get him dressed again he burst out with "oh for Chrissake leave me alane.." so I hung onto that for some reason - you know how you do with abusive difficult patients - and said 'Ok Jummy for his then' and he stopped me in my tracks when a strange different silence came over him before he said gently and thoughtfully, 'Aye he wis a guid mon' and I agreed, and also got his clean pyjama bottoms on!*

'Jummy' had been in the ward longer than necessary as he had been abusive as an alcoholic and his family had totally abandoned him. It fell to the nurses to show him some kindness and human understanding of his inner loneliness and loss of purpose in recovery; apart from that, he died a lonely, sad man. However, another interesting perspective was that 'Jummy' demonstrated that the stories of Jesus as the "guid mon" who was good to people who were 'sinners' or lonely were sufficiently embedded in his consciousness to bring some peace to this lonely angry man in his final days.

This seems to relate to Bradshaw's view of spiritual care by nurses as being ethical, that it is about how we behave towards people. Widerquist (1992) also argued that 'spiritual' is the moral or ethical dimension of life. Yet this 'spiritual' care was very down to earth and embodied in human caring.

Similarly, in the lives of people who are patients, meaning, purpose and fulfilment was thought to be in their social relationships, both personal ones and more widely in society, as Edie said:

I haven't seen spiritual needs...mebbe there have been issues conflicts or something but actually people would say things like 'I wish I had spent more time with my husband' you know, 'I wish I had spent more time with my grandchildren' etc things like that.

Though, she continued, it was surprising how few regrets people seemed to have in her experience as ...*they have died reasonably content with what they have achieved in their lives.*

Edie said that, in her experience family relationships can be very demanding of skills and time so if meaning purpose and fulfilment is more to do with relationships than with transcendental spiritual survival then it is questionable if nurses have either time or skills to deal competently with these. Edie questioned if dealing with painful complex family relationships is any more the role of a nurse than more esoteric aspects of spiritual care defined as meaning, purpose and fulfilment (Ross 1992 et al.) Edie said:

*A lot depends on how much time you've got and how much time the person's got I don't know I have always tried to be available for people if they want to talk let people talk
Some nurses go to great lengths to bring family members up before they die I haven't done that myself though I have supported them in their efforts
I am not a great believer in resolving family conflicts...that family conflicts can be resolved anyway... I would rather listen to somebody if they wanted to tell me there had been a conflict in the family or felt something had gone wrong worrying I would rather let them talk about it and the decisions they have made and if they have regrets and maybe say well it was the right thing to do at the time.*

However on further probing Edie considered this to be part of holistic care and not to be spiritual care as meaning, purpose and fulfilment:

I would have thought it is part of holistic care - sort of touching on the emotional and psychosocial side fitting it all in. I don't really think I would consider it as a separate entity.

Interestingly though, Edie would have considered the same care to be spiritual if the person was dying:

I think if it was to do with things they wanted to say or to achieve or in their final days or whatever I think I would call it spiritual, I think I would call it psycho-social in you know the earlier stages of their illness or of their life even.

Edie's views here linked with earlier the discussion that nurses tend to associate spiritual concerns with the end of life. As Jackie commented in our discussion about whether nurses or ministers of religion should help with spiritual issues:

When people are at the angry stage or about to lose somebody, somebody saying 'it's God's will' doesn't actually help and I think that would put them off.

Discussion

Saunders (1988), from her experience of dying people in hospices over many years, commented also that it is the moral/ethical aspects of relationships which bring burdens of guilt and anger and deep pain in both dying and bereavement and "above all a desolate sense of meaninglessness." (p.30). It was also interesting that Edie perceived of the same relational care as spiritual only if it was in patients' final days; otherwise it was psycho-social. This demonstrated to me how we see the world differently when life is ebbing away and how notions either of a transcendent realm or the need to put things right here on earth becomes revalorised as spiritual rather than relational in social terms.

Studies also identified that counselling and support are valued by patients and relatives when they are facing illness, dying and death, and this is so even of professional spiritual care-givers, such as chaplains or other clergy, and by religious people (McHaffie 2000). Survivors of life-threatening diseases did not automatically search for deep inner meanings beyond the pathological, even if it the diseases are unusual, such as having a stroke at a young age. As might be expected, however, religious people could find strength in their beliefs that they were protected by something strong outside themselves such as "...a huge guardian angel..." or that God heard prayers (Immenschuh 2004:117). On the other hand, Kelly (1994) said that she did not look at life differently after a stroke, even though she had heard that after surviving a stroke people were supposed to.

'Feet on the ground' meaning purpose and fulfilment

Meaninglessness of spiritual meaning purpose and fulfilment

Sometimes nurses felt that patients did need help with finding meaning, purpose and fulfilment in their actual illnesses although for many this was more to do with the causes of their illness. Many study participants said that in their experience most patients want a clinical or physical explanation of the meaning of their illness, and the explanations were more scientific than spiritual.

Reflecting back on her many years in what was then general nursing, Moira said of her understanding of having given patients help with meaning, purpose and fulfilment that:... *it's a scientific explanation people need to explain answers to the Why questions.*

Jane thought that it was difficult as sometimes *there was no reason* to help a mother with the meaning, purpose and fulfilment in the still-birth of her otherwise *perfect baby* and:

...there is no reason - after a post-mortem examination not many say 'yes it's god that's done this' they are looking for a physical reason I just feel you have to give them comfort.

Frequently, there simply was no meaning to be had, even if sought: Agnes told me the story of a teenage boy of sixteen or seventeen she had nursed at home after his diagnosis of a brain tumour, with only a few months to live:

Somebody had asked him, around the time of the diagnosis asked y'know asked why has this happened to you, a lovely guy fit, a runner and he said 'why not me' there isn't an answer for these deeper questions there isn't an answer so how can we as nurses come up with answers? There are no answers to these things.

How you lived helped meaning purpose and fulfilment

Joan, however, saw helping a person with meaning, purpose and fulfilment to be more about how a person lived. In describing her personal experience of the dying and death of her grandfather, when she was twelve, Joan said:

I remember, to be slightly personal, when my grandfather died, and he had a diagnosis of lung cancer, he was on chemotherapy, he expected he'd live six months, but unfortunately with the chemo he took pneumonia because his immune system was compromised and he died very suddenly but he had no faith at all, just didn't, didn't bother him and I remember when he was dying he said 'that's me done' and died, and I was only 12, and remember thinking that's ok too and he had no purpose, that he was going to, 'that was it, his time was up and that was it! but he had meaning, purpose and fulfilment in his LIFE - he had LIVED, not in his death or his living but because of the individual, I always thought my grandfather was very spiritual in that sense because always thought he was very full as a person something to be admired in that and I thought when I get to his age I would like to think well I have had a good wee life, and mebbe there isn't anything else - be great if there is but mebbe there isn't there was no need to he wouldn't have.

Towards the end of her illustration about her grandfather Joan reflected on whether or not a nurse could have helped him with meaning, purpose and fulfilment:

...or mebbe if somebody had sat with him I don't know mebbe it would have helped him [with meaning, purpose and fulfilment] but don't know if it would have either.

It was not just in the dying process that nurses could appreciate the need for patients to have help with issues of meaning, Joan felt, in mental health nursing, in particular, meaning, purpose and fulfilment could be important:

Finding meaning and purpose within a framework of ill-health I think it is so true for me who I think is a reasonably healthy individual, and for everybody, I think it's more obvious in nursing cos you are presented with illness and death and again we're back to that 'it's in your face' you need to deal with it ehm but I do think that would be true too, in that to find meaning, purpose and fulfilment and how you do that as an individual or a nurse or whatever I am not sure and I do play around it.

When Joan spelt out what she thought the nurse should do in helping a patient with meaning, purpose and fulfilment, this revolved around nursing care practices. In her experience, meaning, purpose and fulfilment was saying to a patient:

... 'what you did there ehm was, I felt was I was very unhappy about, disagree with and be able to focus on (their particular behaviour)

Joan was taking a more down to earth interpretation of meaning, purpose and fulfilment than Ross et al in their definition of it as spiritual care. She identified affirming individual self-worth ... *just to give an example of how you may do it in terms of you can still be very positive about a person...* and acceptance of the person as they are, as she said: ... *if you value somebody for themselves, warts an' all.* Helping a person to feel positive about self-worth issues is already part of good nursing care, so it would be important for a nurse to be clear how spiritual care as meaning, purpose and fulfilment differed if at all from what Joan described.

Practical care: doing and being affects meaning, purpose and fulfilment

Jane, was very pragmatic about meaning purpose and fulfilment, said that if patients were ...*not really being taken care of they can't find meaning purpose or fulfilment can they if their care is not good.* Jane had been telling me about her visits to an elderly friend in hospital who was very ill, but whose meals were left on a table too far away from him to manage and nobody helped him or seemed to care. She said:... *I don't know if that comes into spiritual care or I suppose it does in making somebody comfortable.*

To Jane, the nurse was unlikely to be able to help the patient with meaning, purpose and fulfilment issues if the basic care needs were poorly met or, worse, neglected. Indeed Jane thought that the nurse's role was to give good all round whole person care, caring for all their individual needs: ...*you do everything you can for a person you know so you are taking care of their mind body and spirit.* As she had explained to me earlier, with concern, she had not found that this was the case in the hospital in question, either for her elderly friend, or another friend who had died three weeks earlier in the same hospital:

From what I saw the care wasn't all that hot she died very quickly. It was the general nursing care. I mean for example there was like a – she had a real bad chest she was a bad asthmatic and there was like a bowl sitting there – oh this is nothing to do with spiritual care! mebbe it had spit and old tissue in it and two auxiliaries came and made the bed next door but didn't lift it up so I lifted it and put it on the - I just don't think the care is as good there too much emphasis on paperwork.

Jane also commented that in her experience as a midwife people wanted practical explanations as to why the baby was still born: *...they're more looking for a physical reason*. She thought that when a mother had the distress of a still-born baby the role of the nurse was to try to give comfort, which she did think of as spiritual.

Isla said in her experience in acute surgery/oncology, meaning, purpose and fulfilment was:

Support and time to listen the time even just to be with a person not even that you have to be sitting there saying and talking, but you're just there to listen you're there to comfort, the person's not alone I think it's such a difficult think it's so hard to put words to it I think that's the whole thing - it's so hard to put words to it!

Similarly Moira, who worked with children who had learning disabilities, it was the practicalities of caring which held out any possibility of meaning, purpose and fulfilment in nursing though – as a mature and very experienced nurse she appeared bemused by the whole concept and that spiritual care was incorporated in caring by practice. She said:

You know I just feel I am doing my job- it is all encompassing care. You do need that sort of attitude to the job: I see it as encompassed all the time.

If she gave spiritual care to them in any way at all but if it was as meaning purpose and fulfilment, she was visibly perplexed, and said, thoughtfully:

Listen and discuss but no answers only possible suggestions. It is difficult, because of the communication barriers there is a lot of nonverbal communication - they have a lot of trust and in lots of ways they give a lot to me so it is a difficult question

Apart from giving the total care described above, Moira concluded by saying anything else would be prohibited because *there was not enough staff*

Reflecting back on whether she had given spiritual care as meaning purpose and fulfilment in her years of adult general nursing, some thirty years earlier, she said:

I think we tried to help people with it though we didn't call it spiritual care. I think it was more that we listened to people, when we had time, especially in terminal care or with cancer patients. I think I might have discussed rather than dictate I don't have any answers.

However, perhaps due to her earlier background as a Church-goer and, as it happened, her family connections with people who were religious academics, she also thought that *people seem to need something concrete to hang onto spiritual care not sure...*

Discussion

Isla's account made me realise the value of feminist approaches in an area where so much about valuable care is difficult to verbalise. Her words: *...it's so hard to put words to it - I think that's the whole thing it's so hard to put words to it...* were almost like a cry of frustration when she told me, yet could not say what it was that actually transpired between patient and nurse in such times of closeness.

The frequent explanation of nursing care as both practical and psycho-social echoed earlier studies into the role of the nurse as a comfort and support, yet these were frequently either taken-for-granted: *...just my job* (Moir) or *...the care you just GAVE*, were increasingly identified as spiritual care. However as indicated already this could be due to the focus of my study. Perhaps if I had not mentioned spiritual care the nurses may have described their experiences of nursing people in more personal terms such as that described by Smith, Salvage et al and which I discussed in Chapter One.

Summary

In summary, in this chapter the experiences of the nurses demonstrated their disquiet about spiritual care constructed as meaning, purpose and fulfilment particularly if this meant dealing with deeper existential questions. They felt nurses had neither the time nor the competence to deal with such complex issues. Apart from the need to find meaning purpose and fulfilment in life, the remainder of the needs are to be provided for through professional practice as specified in the Code

of Conduct (NMC 2004) as well as government guidelines such as the Patient's Charter (1991).

CHAPTER FIVE

Nursing care and spiritual care

It's such a difficult thing to put words to the care you just GIVE to the patient

Lilian - Study Participant

Whereas in Chapters Three and Four I discussed the nurses' understandings of spirit and spiritual care and if this could mean helping patients with finding meaning, purpose and fulfilment, in this chapter I focus more on the nursing, and what interviewees considered to be spiritual in that process. As we saw in the previous chapters, separating these topics was difficult because of the way they are intertwined within the stories nurses told of nursing people. Indeed, spiritual care was often described as synonymous with nursing care of the person, and was something they just 'gave,' or were, as nurses. In this chapter therefore I specifically try to see how they thought of spiritual care as different from personal or bodily nursing care. Again, the nurses grounded their experiences in stories of people in mental health, midwifery, acute surgery, care of elderly and learning disabilities. Some parts of the stories have already appeared in the previous chapters. Here I attempt to separate out the nursing aspects to investigate why spiritual care should be expected in addition. Frequently, these related to loss, dying, or death and to inner distress, which the nurses perceived as spiritual.

In this stage of analysis I put more emphasis on why 'nurses identify nursing as spiritual care.' At first I tried to form categories from the conversational material and to go on to cluster these, as in grounded theory. As I noted above, I had already experienced difficulties with this process in the earlier parts of analysis of the conversations. In this stage of analysis, when trying to probe whether existing nursing care categories, such as comforting, were spiritual care, I again found difficulties in trying to represent the individual voice of each participant, as well as our conversational interaction. As in the actual interview conversations, when I read and reread the transcripts, I noticed again and again the difficulties the nurses had in trying to articulate differences between nursing care, such as comforting, allaying

anxieties by good communication, and so on, from spiritual care. *How do you describe the care you just GIVE?* was a typical expression, suggestive of perplexity. Indeed, for the most part, each person could only talk about the spiritual care of a person by describing specific situations of nursing care. Aside from religious/cultural care, spiritual care by a nurse was frequently cited as competence, communication, compassion, caring and companionship. The process of forming analytical codes, categories and theories only partially represented this, whilst it did not at all depict the individual voice of the nurse, nor the difficulties she had with articulating the experiences. My notes after the interview with Jackie said:

She raised lots of relevant points relating to my attempts to glean how/ if spiritual care is separable from holistic bodily care. She raises (?significantly right at the end) her own experience as a patient, and her perception of how nurses and nursing seem to be missing out on caring, even basic human skills such as talking with the patients. In her own experiences of giving care, what predominates is the need to be there, to listen, support and comfort, especially at times of dying and death, and to give adequate information. All of these attributes, and more, are what Bradshaw (1994) describes as competent nursing care. (04/12/02)

Care, comfort, communication and companionship as spiritual care

Being and doing as spiritual care

The human qualities of caring, comforting, companionship and communication all featured significantly in how the nurses described spiritual care by nurses. Many nurses said, directly or indirectly, spiritual care was often comforting and being with patients. 'Time to be with a person', 'sitting with them', 'just being there for somebody', and especially, *you helped people when they were ill or dying*, as Jane said, and similar expressions, recurred frequently. Often, spiritual care was described in terms of good nursing care.

When I asked Edie to say more about the colleague she had described as spiritual she said: *giving comfort she was great at a soothing level which was sadly missing in the area* [acute psychiatry] *at the time*. Jane likewise felt that;... *if you are giving*

comfort to people then you are giving them spiritual care,... going on to say that somehow you do if you are a carer or a nurse [...]

For Isla there was a quality of ‘being there’: *...to listen to comfort so the person is not alone,...* Yet this ‘being there’ can be very difficult especially for nurses Isla described it well:

Support and time to listen...the time to be with a person not even that you have to be sitting there saying and talking, but you’re there to listen you’re there to comfort, the person’s not alone I think it’s such a difficult thing.

Isla continued that it was often

Just doing the best you can with all that’s going on and the time, just being with the person and with the family members as well, yes I think I would probably look on that as a link with spirituality and that in these instances ehm I don’t think you can separate it...I think it’s integral and I don’t think it can be separated out and be purely holistic if spirituality isn’t there.

Agnes thought *just sitting and being with somebody [pause] quietly calmly can communicate something which is comforting [pause].*

Lilian also felt that

It’s about sitting with them and getting them to talk if they want to express their fears... to the palliative patient you obviously don’t want them to be distressed, you’re trying to make them as comfortable as possible and that is not always about medications.

Isla also thought ‘being there’ was spiritual in some way, and this was particularly so when patients were distressed in any way. This was interesting in the light of the studies discussed in Chapter One, where nurses felt that their innermost care of patients was ‘natural’ and so not spoken of. Also, studies discussed in Chapter One demonstrated that ‘being there’ involves entering into the patient’s deeply personal experiences of loneliness, grief and struggles. Isla said she needed to be there *...when they’re not happy, or upset, when they’re bringing out their emotions as it’s such a*

difficult thing. For Dorrie it was:...sitting down with them when they are upset; Lilian it's about sitting with them and getting them to talk if they want to express their fears.

Isla also said:

I would say is partly spiritual...it's one of the most powerful things...I was glad I was there because I was with the patient at a crucial time of their life...I dunno I dunno I would say that's spiritual in a way.

...

...sitting down with them when they are upset, holding them, touching, talking, dealing with people, responding to their needs. Not just giving out basins.

Discussion

All of these instances of care highlight the fact of the nurse's presence as caring comfort which is invaluable yet not entirely visible or validated, apart from within the interpersonal caring relationship, just as caring by women as mothers and related roles had been seen to be in studies described in Chapter One. However, I was interested in how the nurses tended to call such caring activities spiritual, although they were not sure about it. This too may have reflected the cultural acceptance that intimate care had a special quality to it which might be called 'spiritual'.

Being human

Being kind, compassionate and caring for the individual patient as a person, as a fellow human, were thought to be spiritual, which was also equated with being human. Judy, the Stroke Specialist Nurse, and a practising Christian, said she found:

...it difficult to separate being a nurse from being a human being and nursing as a kind of professionalisation of how human beings should interact with each other... spiritual understanding being actually the most important thing about our condition as human beings.

In the cold and unfeeling experience of acute psychiatry in 1980s, Edie felt that one particular nurse was *spiritual* because

...she was a human face, she was the human face in the ward though I don't think she set out to do what she did, a very human person, people

...who were distressed gravitated towards her...people found her helpful, she had a humanness and warmth about her, not motherly...she could be hard - wasn't soft love she was caring.

And Joan said:

I think the thing is for myself and in nursing I'll keep this brief and - but I kind of think of it as a human being we should be doing it as a human being to another human and nursing is no exception.

But what was spiritual about being human? Dunbar (2004) in *The Human Story* argued that what distinguished humans from their near evolutionary relatives, apes, was religion, or the world of the imagination which, he argued, was crucial only to humans. It was, Dunbar continued, the social sense of community, fostered by story telling and religion⁶⁴, not individuality, which distinguished humans from other animals. Hume (1778) argued in *Dialogues Concerning Natural Religion* that it is our disposition to sympathy with and for each other which distinguishes us as humans because, over time, we have learnt that this enables us to live together. However, these arguments deal with an entirely natural morality, not revealed by any God, as Bradshaw (1994) and religious people would see it.

I do not think the nurses in my study necessarily meant to equate spiritual with being human in the way Hume or Dunbar did. However, it is a good illustration of the confusion that surrounds the whole notion of what spirituality is and, furthermore, how a nurse can give spiritual care. Furthermore, it was interesting from a feminist standpoint in that the nurses gave this emotional bodily caring a religious 'gloss' by calling it spiritual, a sort of 'metaphysical presence' rather than accepting it as 'just' human or 'natural'.

It's hard to put into words

As I said in the previous chapter, the nurses' personal and professional views of spirit and spiritual were often intertwined. If the nurses were unclear about how, or if, the spirit could be separated from the self; who made the person who they were; their

⁶⁴This was not to say, however, that religion was necessary to be human, but that of all animal groups, humans were the only ones to have religions since this enabled the human group to appeal to a higher authority, namely the gods, to get people to conform.

personality, personal history or identity, character and so on, whether spiritual care could be separated from good nursing care was another interrelated difficulty. Often they were unable to find words to express their experiences of this aspect of nursing care. Isla expressed what was very common amongst my study participants: *I sometimes find it difficult to say exactly how I feel and you know trying to find the right words – hem.*

Isla, who worked with dementia patients, also said: *It's so hard to put words to it I think that's the whole thing - It's so hard to put words to it.*

In trying to explore Isla's understanding of spiritual care in nursing, as with several study participants, it emerged that spirituality was difficult to explain and could only be attempted by talking about nursing patients. Below I give an extract of my conversation with Isla to illustrate this. Isla responded to my asking her what she understood spiritual care in nursing to be by saying

What I understand as spiritual care? I think, can I, just I know when I was reading the introductory letter from you [explaining the research]... I think when you first came into class and said what you were looking for I thought 'yes I'd be quite happy to give you a hand' and when I read this [letter] I thought 'oh I don't know [laughter] I don't know [laughter] ...there's something...

After quite a lot of discussion about spirituality we came back to Isla's understanding of giving spiritual care as a nurse:

What I really mean is what do you understand by spiritual care in nursing really?
uhm uhm ehm I think it's [pause]...eh... [pause] allowing the person you're nursing to express their own spiritual needs...they maybe haven't been a spiritual person throughout their life.
A spiritual person...what do you mean?
I'm not sure I'm meaning a spiritual person as such.

Isla struggled first with saying what spiritual care was. Then, once she decided it was about letting the patient express their own spiritual needs as *maybe they haven't been a spiritual person*, she was not sure this was what she meant after all. Like many

other participants in my study, she was very thoughtful and said she had not really thought about it much in nursing before the study.

What the nurses described as spiritual was good nursing care, which they found difficult to express, and, as significantly, that it was hidden or something they just GAVE. As we saw in Chapters One and Two, this hiddenness of care of a person's emotions, as well as bodily needs were attributed to the gendered nature of caring.

The care you just GAVE unconsciously

Intrinsic care

Lilian said, after a thoughtful silence: *it's such a difficult thing to put into words the care you just GIVE to the patient*. In fact, the nurses often considered spiritual care to be *more inherent in the way you are with patients* as Agnes described it, whilst Joan, similarly, said it was *the way we are with people*. It was just something they instinctively knew patients needed yet, or because of this, they were unable to be clear about either the patients' needs or what it was they as nurses did or were to meet these needs described by them as spiritual in our conversations. Isla reflected on their practice, and supposed nurses

...give spiritual care unconsciously...how do you define it, how do you put your finger on 'that's exactly what they are needing'. I think it is just something you know [laughter].

If the nurses were able to articulate the care they gave, and this was similarly recognised as meeting patient needs, would nurses be required to give spiritual care in addition? This was my research quest: Why were nurses being asked to give spiritual care and what was spiritual care in the first place? It was significant that the nurses also just as frequently described close intimate care as spiritual. As Joan said:

...the very act of caring for people intimately as nurses and particularly over a period then we do it in such a way that hopefully provides a certain spiritual comfort for the person.

Jackie also described spiritual care as “intrinsic” to good nursing:

The spiritual care you give is intrinsic in the way that you treat them in the way you respect them as people if you like in your code of behaviour in the way that you would look after somebody...so I think spiritual awareness in nursing is important.

Again I thought about how spiritual care as described by Jackie was different to good nursing care as I entered in my reflective diary after the interview:

She raised lots of relevant points relating to my attempts to glean how/ if spiritual care is separable from holistic bodily care. She raises (?significantly right at the end) her own experience as a patient, and her perception of how nurses and nursing seem to be missing out on caring, even basic human skills such as talking with the patients. In her own experiences of giving care, what predominates is the need to be there, to listen, support and comfort, especially at times of dying and death, and to give adequate information. All of these attributes, and more, are what Bradshaw (1994) describes as competent nursing care. Though interestingly she also draws pertinent comments about how syringe drivers have allayed patient anxiety in dying whereas even with good quality care (presumably) anxiety had been present say 5 years previous. But this is just generalisation here. (Reflective Diary 03/12/05)

Earlier in the thesis I discussed the elusiveness of the concept of caring in nursing (Morse et al, 1990) and studies into the qualities of a good nurses as being personal kindness and friendliness in addition to knowledge (Evans 1991) and Mason (1990); practical. Both the doing and being of nurses have been seen to be important to patients (Davies & Lynch, 1995) and across a number of different care settings cross-culturally (Bjork 1995). However, this intimate caring was described as spiritual by nurses in my study and I wondered why this was. Additionally, the care of the nurse described as spiritual related to those activities which were by their very nature mainly hidden or as Lawler (1992) described it in her study, “*Behind the Screens*”. Was it that nurses were telling me about these care experiences which they had not spoken of much if at all, or perhaps not had recognised as of particular importance

and recognition? The story of the *alcoholic man* told by Agnes described the complexities of care well:

I suppose I'll maybe just tell you about a patient um he was an alcoholic man, had years of alcohol abuse for several years and his family had about abandoned him although his ex wife did still come in and do his shopping and washing and he had terrible psoriasis and the GP asked us to go in and actually my colleague was the main nurse involved with him and for several months um for several months, a long time, he had daily visits and skin care and his skin improved a great deal, um he was certainly in the beginning very irritable and rude sometimes a little drunk, not terribly easy, but what he did get in these months before he died was consistent, courteous um care, from the majority of us who went in; um occasionally one or two went in at a weekend, gave his care in a very brisk way and that upset him but I think what he got was spiritual care, because I think spiritual care is associated with acceptance regardless of what the person is like um ...I think what he did get was some sort of spiritual care and acceptability, spiritual care which was hopefully some sort of comfort to his inner self I suppose...I suppose spiritual care is some sort of background which is more inherent in the way you are with patients.

Here Agnes described her experience as being about both how the nurse behaved towards the patient ...*some sort of background which is more inherent in the way you are with patients...* and also the patient's nursing care, though they tended to be intertwined. In describing the way this alcoholic patient whose *family had about abandoned him* was accepted by the nurse Agnes demonstrated how unconditional acceptance and positive regard of a person who is a patient is good professional practice. This was shown by being patient and understanding of his needs particularly when he was ...*very irritable and rude sometimes a little drunk, not terribly easy - what he did get was some sort of spiritual care and acceptability*. She demonstrated how, when the nurse was patient, ...*courteous and consistent...* in nursing care, and accepting of the patient, this was ...*hopefully some sort of comfort to his inner self I suppose...* where his *inner self* was his spiritual aspect. Care that is rooted in concern and ethically based altruistic love for another is what gives peace of mind and enables healing or peaceful dying. This chimes with Bradshaw's thesis that nursing is spiritual in itself, when given with compassion and in a competent manner, without

adding another care category of 'spiritual care'. It is interesting that when some nurses did not act in this way with him, he became distressed.

The ethos of care

Since Agnes identified *spiritual care as some sort of comfort to his inner self*, I tried to explore further with her how this differed from psycho-social care. She said:

So how does it differ from psychological care [pause] I don't know I suppose in psychological care the person has some sort of problem you can discuss with them, you can discuss some sort of strategy some sort of coping, but I suppose spiritual care is some sort of background which is more inherent in the way you are with patients.

Here Agnes found it difficult to say how spiritual care was different from psychosocial care. For the most part, she merged the two categories, although she later explained she thought of this self as *more the outward, social face*. However, interestingly she decided that spiritual care was *more inherent in the way you are with patients*. Her understanding of what the spiritual part of a person might be was *...being in touch with the spirit you have to move to a deeper layer of the self and* [pause] *yeh*.

If this deeper layer of the self was the spirit how did care of it differ from psycho-social care? As I also discussed in Chapter One, the neuro-psychological as well as philosophical literature suggests strongly that there is no spirit separable from the self created from the biological and social contexts of individual life stories.

Agnes also merged nursing care with professional ethics: she believed strongly that acceptance and affirmation of the individual's self worth was spiritual care. However, apart from acceptance and affirming the individual self worth, Agnes was not clear what the spiritual care of the person was:

Again I see spiritual care is about affirmation of worth for somebody and I think as health professionals it is something we can always give to somebody even if we can't change anything else at least if we can accept somebody as they are and listen well at least we can give that.

There was a sense that the very least, if not actually the only way, the nurse could be with such a difficult patient was to accept him as he was, and when this was not possible with other nurses, he had become distressed. But Agnes could not clearly distinguish between this professional ethical mode of being and how or whether this was the newly emerging category of care called 'spiritual'.

A similar ethical dimension could be detected in Joan's experience of caring for patients with mental health problems, which she said *...was if you value somebody for themselves, wants an' all*. It was to this ethical teaching Bradshaw (1994 1997) referred in her argument that if nurses were compassionate, competent and caring there was no need to give spiritual care, indeed, that such nursing care of a stranger was spiritual in itself. But this was different to the spiritual care strongly recommended of nurses in the relevant literature and which I discussed in Chapter One as being about finding meaning, purpose and fulfilment in a transcendental realm, however this may be defined (Ross 1992 et al). This is not to say, however, that spiritual care so described need necessarily preclude wider caring, but my study is to enquire into why transcendental spiritual care is required of nurses.

Everyday care: was it spiritual?

Not all caring was as multifaceted as that described by Agnes, though disentangling what was spiritual from what was everyday nursing was complex. Edie reflected this when she described spiritual care as standard nursing practice when she had worked with elderly people, *...though at the time I probably wouldn't of thought of it as spiritual but it probably was*.

Then, she explained, she *...helped them look at their experiences in their lives and things in context, in perspective, things they may have worried about*. Here Edie described her difficulty in separating out the spiritual from nursing *...I suppose a lot of that work was spiritual* so she identified this helping aspect of nursing as spiritual. As discussed in Chapter One, The Royal College of Nursing (1992) identified good nursing care as often demonstrated by the fact that you cannot see it, whilst Savage (1995) and other nursing scholars showed that nurses found it difficult to articulate the 'closeness' they experienced with their patients. These difficulties were also reflected in the accounts of nursing by the nurses in my study.

However, it was unclear both to the nurses and me how psycho-social care could be distinguishable from spiritual care. Moira, thought spiritual care was *more their WELL-BEING* whereas Edie and Agnes did clearly identify the same caring practices as spiritual. But Agnes had earlier said she saw her care of the well-being of children with learning difficulties to be what they needed from her as a nurse *rather than any religious or spiritual aspects*. With this group of vulnerable people Moira tried to tease out the complexities of nursing care, and said:

I try to give [reflectively] whole person care? I don't know - it's difficult with children with learning disabilities because of the communication barriers - they have a lot of trust and in lots of ways they give a lot to me so it's a difficult question if I give spiritual care to them.

Discussion

I thought the nurses' inability to articulate what they obviously considered essential nursing care was very interesting in the light of existing nursing research discussed in Chapter One (for instance Hart 1991 Lawler 1991, Savage 1995, Smith 1992).

The nurses in my study so often spoke of personal care as spiritual, however variously it was defined, almost as though it was natural and unlearned on the part of the nurse, as being 'just there,' or something you 'just gave', or: *how do you put your finger on it? It's just something you know*. This was very important in my study, because it suggested that the intimate care they gave was largely unrecognised, even by them. Caring by nurses has been demonstrated as most valued by patients and relatives as well as by nurses, including those in my study. I wondered why the nurse in my study considered their nursing care to be spiritual care and not nursing care. However, as in the other studies cited here, they found it difficult to articulate what was spiritual about their care, apart from describing their caring practices and activities as spiritual.

Moira, who had more than thirty years experience across a wide range of nursing but who was working in a home for children with learning difficulties, said: *not sure I know what spiritual care IS*. She went on to demonstrate the difficulties she had in seeing how she could call: *doing my job* spiritual care yet at some level she put a value on the trust that developed when she listened. Indeed she came near to saying

that was spiritual care: *it is all about listening* to feelings and concerns parents had with a child who had learning difficulties. She further considered spiritual care to be *all encompassing care*, though she concluded by saying:

...it is all about listening [to parents] and hearing...it is all encompassing care. You do need that sort of attitude to the job - care all the time - not sure I know what spiritual care IS...

Moirra was convinced of the importance and centrality of caring for the whole person, their *well-being*, but was unclear as to what the spiritual aspect of that care was. Like Agnes and Joan, Moirra thought acting in a way that ensures the well-being of another is located in ethically based practice (Tschudin et al 1993). This they thought of as 'spiritual.'

Like Agnes, Joan, Jackie and Isla thought the way they were with patients, their acceptance of them as people and the way they behaved with professional care and kindness, as well as technical competence, was spiritual. In this sense Agnes described what Bradshaw (1994, 1997) said was good, competent, compassionate nursing in that it allayed patient anxieties through fostering trust between nurse and patient which thereby brought peace of mind. This, she argued, was spiritual in itself because it is rooted in the Judeo-Christian ideas of service to a person who is believed to have been made in the image of God.

If spiritual well-being is being at peace within oneself, and with others, then Bradshaw's view is significant in the context of Agnes's experience. Both Agnes and Jackie effectively described good nursing care as consistent with ethically acceptable professional behaviour, already required by the Nurse's Code of Conduct (NMC 2004). The latter says it is a professional duty to nurse the person with respect and dignity, with implied acceptance, regardless of the reason for their illness. Agnes and Moirra also thought that: *if I give spiritual care to them you know I just feel I am doing my job*. As with Agnes and Jackie, spiritual care is seen to be about relationships and caring skills. Ailsa also thought: *bringing out their emotions I would say is partly spiritual*. This raises questions about the qualities of the nurse as being what defined spiritual care, rather than any giving of specific spiritual care: *just the way you are*. However

this is not just 'natural' but a set of interrelated skills and knowledge as Lawler (1991) et al demonstrated.

Agnes described clear physical distress of the patient she was caring for: the patient needed *daily visits and skin care* for his psoriasis. She fused this physical care with his socio-emotional needs for acceptance, even love, since his family had *abandoned him due to his alcoholism*. In this way Agnes conveyed a sense of altruistic love, or care for another. This person-centred care is more than just physical presence but actively 'being' rather than merely doing. Such care involved 'skilled companionship' (Campbell 1986) and '*Being There*' with others in their times of distress (Speck 1988) whilst Bradshaw (1994) called this 'spiritual.' Agnes and Moira, and others, described the complexities of skilled caring in which physical, practical and technical care is fused with psycho-social care...

It was in attention to caring about the details of physical care that nurses in my study thought caring for spiritual needs of patients could be demonstrated.

Earlier I said how Jane described her distress at poor concern for the whole environment of the patients, such as unemptied bowls on the bedside locker when a close friend was dying in hospital, or a meal left out of reach of her elderly, dying friend. These nurses were themselves unsure that these actions or lack of actions were spiritual; yet their very concern demonstrated the indivisibility of care which made the person feel valued and cared for, or not. Similar points were raised during a meeting with a supervisor who told me about her experiences during recent elective surgery:

Recent, personal elective surgery created on-going discussion about nursing care which was relevant to both my information and questions about nurse's role in spiritual care-giving. What may seem insignificant or unimportant technically to a nurse is very important to a patient e.g. being dependant on another, being scared where to put the part of the body which is sore, meant the patient had to do all the working out of what to do next since the nurse, though present, did not take a lead, nor act responsively e.g. helping with clothes when moving from chair to bathroom, or using a commode. She said, "You're on your own though you're with them [the nurses]"

(Notes on Supervision Meeting 19/12/02)

During another PhD supervision meeting I was surprised to hear similar findings:

The recent experiences of being a hospital patient gave her many helpful insights into the role of the nurse, and questions about spiritual aspects of care. I will hopefully be able to incorporate this into my discussion of data since much of it supports existing work by Bradshaw (1995). Indeed, most work reporting views of patients or/and practising nurses comments that what matters most to patients is the kindly, competent, caring presence of the nurse, and appropriate practical help. Interestingly, both my supervisors had personal experience of hospital nursing during the last year of my study and each says the same! Apparently small gestures, which were important to her as a patient, were:

- holding the patient's hand;
- repeating that "all is well..." several times during post anaesthesia drowsiness;
- going to the trouble to get mousse for the patient's hair;
- using terms of affection such as 'Dear' or 'Darling' which show affection, love even;
- changing the water in the flowers to keep them fresh.

Although my supervisor called this a "feet on the ground spirituality", when discussing her experiences of being a patient with me, I wondered if use of the word 'spirituality' was because I was researching spiritual care by nurses. Might she otherwise have called it good nursing care? To her as a patient, 'spirituality' was broken down into everyday care meanings – how the nurse behaves towards the patient was of vital importance. These acts and ways of being a nurse were how patients understood 'spiritual' care for patients by nurses. A patient can describe or experience it as part of the healing process. It gives the peace of mind necessary for healing to take place. This was the argument made by Bradshaw (1994). The nurses, my supervisor said, practised "a relational way of caring", which, interestingly she called "feminine spirituality". This, she said, was obvious to her, whilst the male doctors behaved more as if the patient was a business client. The doctors did not show much understanding of the patient's alarming situation, even denied her rights as a person for respect and dignity, and denied her inclusion in the decision-making process. Particularly in not attending to her innermost feelings and fears she felt de-personalised and uncared for. This caused unnecessary distress, which, I would argue, no amount of 'spiritual' care added on could undo. This relates well to Bradshaw's thesis.

Affirming self-worth as spiritual care

In Chapter Three I described how Agnes, who had worked in an inner city socially deprived community, where *...there are quite a lot of problems all focused in that small area...* described how people had *...an immense amount of poverty of spirit.* She had found it difficult to distinguish between spiritual and psycho-social poverty, where, as she acknowledged, *... their opportunities for developing the inner self are reduced in areas like that:*

I have worked with young people, men and young women and young women who have experienced sexual abuse, and so often they say they hate themselves, that comes out spontaneously

I asked her to expand on her earlier description of *...poverty of spirit...* which she thought was due to *...low self-esteem and that goes with a low spirit and a low sense of self-worth and the essence of the self inside.* I extended our conversation further to see if, or how, Agnes distinguished between spiritual and psycho-social poverty which she described as *...to do with the daily grind of not having enough money...* because she had attributed this *...poverty of spirit...* directly to social deprivation, in turn, *...partly due to loss of hope and aspiration.* Here Agnes saw the nurse affirming the individual's self worth as spiritual care:

Agnes found: *... um people have children very early on and quite and they have behavioural problems and y'know...* so here too, depressingly, Agnes described the poverty *...as maybe health not so good there is a high incidence of smoking, obesity, lung, heart, everything*

On further probing, to see if she could differentiate spiritual from psycho-social care, she said:

..uhm uhm I think that is quite difficult I was thinking about that. What is the difference between caring for somebody's psychological needs and caring for their spiritual needs and I think, I don't know, I didn't always feel entirely clear about that side of things.

It was interesting that when I first met Agnes she was discussing this very matter with a male colleague who was a philosopher. He was arguing strongly against the existence of spirit, whereas Agnes was equally strongly arguing from her clinical experience of working with people that spiritual care was important. Describing what she considered to be spiritual care of the difficult alcoholic man who was lonely and unloved by the family he had abused, she said:

I think spiritual care is about affirmation of worth for somebody and I think as health professionals it is something we can always give to somebody at least we can always accept somebody as they are and listen well at least we can give that.

Here Agnes clearly perceived spiritual care by a nurse to be acceptance of the person *even if we can't change anything else*. Here Agnes particularly seemed aware that poverty of housing and opportunity for advancement negatively affected the health of clients in the community in which she was working. She saw spiritual care as listening and reaffirming the human worth of the individual. Agnes also thought of the spiritual part of the person as *...the essence...* and significantly talked about how poverty grinds people down so they lose hope and become dispirited. When I probed her understanding of the spiritual part of the person she could see that if the person *...had strong religious faith this could give them comfort and meaning and guidance and whatever*. Agnes saw her own role as a nurse in spiritual care in such *hopeless* social circumstances as finding something *...positive about their lives um it's small things I guess*. Sometimes she saw this as: *...encouraging people the way y'know they are doing a good job in raising their child*.

This sympathetic account raised in me questions about spiritual care though, for if it is about finding meaning, purpose and fulfilment in some transcendental spirituality as Ross et al argued, and is not about improving the social conditions affecting health, then how would such spiritual care help such people? This was the feminist critique of spirituality that separated itself from everyday life in all its messiness to promise a better life beyond, when what was needed was political and related action to improve the quality of bodily life, such as good housing, education, food and social environs conducive to health.

As Agnes had worked in South India with ...*an atheistic NGO actively promoting scientific approach and trying to dispel all superstition* I expected she would be sympathetic to political means of alleviating poverty of spirit and indeed she did not believe in any god herself, preferring yoga and dance and nature. On the other hand she believed ...*the spirit was something a little deeper. The self is more outward.*

Converse of caring

Many nurses, however, spoke of experiences of nursing as the converse of the caring presence described in the interview extracts above. This was significant since if the caring and comforting was perceived as absent as it frequently was, if the patients were not cared for in a fully human way, the nurses described this as a good indication that spiritual care would be required. In short, they identified caring and comforting as spiritual. They talked of the National Health Service (NHS) as comparable to a factory production line, where people are not given the care they needed and, just as significantly in my study, nurses felt unable to give skilled nursing care. They spoke of not having time to be with, or listen to, people if they wanted to talk.

I had the skills already

Whilst nurses and patients valued the intimate, personal nursing which constituted good nursing practice, this was often subordinated to bio-medical care, management structures or even personalities. Jackie, who had worked in children's nursing, found that especially in General Adult Nursing she

...had just been robbed if you like of the ability to practise...Talking to people, the caring, the time, all those things that you, a lot of us came into nursing for but has been eroded, so that it wasn't there...I was managing a busy ward and ehm it was busy and there weren't beds and there weren't enough staff and you know things change and so it wasn't that I didn't have the skills they were there already it was just the opportunity to use them in an environment where, if you like, people expected me to use them.

Jackie said what many nurses did directly or indirectly: *...it wasn't that I didn't have the skills they were there already.* She also talked about how her skills were subordinated by bio-medical practices, as well as lack of staff, causing her to feel disillusioned indeed *robbed of the ability to practise.* She went on:

You've got ten IV drugs to do and the person in cubicle two is crying her eyes out or not crying their eyes out but sitting you know terrified you know you just know when somebody wants to talk so short of splitting yourself in two what do you do? You do the IVs don't you and hope you have time later but then maybe that moment's passed and she'll say no no this isn't the time and they never get the opportunity.

Interestingly, the very invisibility of nursing care was itself considered a spiritual matter, though this was not always recognised as such by the nurses, though some did, because of the distress it caused them and their patients. Isla, a staff nurse in an acute surgical ward, said:

[...] the consultant will say 'You know you have cancer'. Walk off! And the patient stunned! Yes! And you're there and say 'I'll come back' [softly] and you pick up the pieces. At the time you want to kill the surgeon [laughs] kill the surgeon. They sometimes break the bad news without the nurses knowing! and that drives me absolutely round the bend because I want to be there, to know exactly what they have said to the patient... so many times I've gone in and patient's crying and you think 'what's happened?' and they'll say to you 'I've just been told' And I have to say 'I'd love to have known how he told you' oh it's happened so many times well certainly the experience I've had, I've had some junior doctors blurt out in front of patients and the patients didn't even have a clue and you'd like to take the doctor around the back and give them a few choice words, 'You must think before you speak!'

Instead of using communication and caring skills, and without even mentioning to Isla or any other nurse when, or how, or even what was to be said, the surgeon told the patient the diagnosis. Then he left her with no support organised and with no understanding for the distress the bad news would cause her. This upset both the patient and the nurse who had the added feelings of annoyance with the surgeon to cope with. Being proactive, planning how to give the bad news and for the support mechanisms to be there for the patient were recognised as important by Isla, but her

skills and knowledge of what was necessary for the patient's care were overridden by the dominant role of the surgeons. This was what Isla considered to be spiritual care - or lack of - for the patient.

Time and touch

Lack of time was a frequently mentioned reason for not being able to give the kind of whole person care the nurses felt a patient needed. Higher patient turnover was also commented on for limiting the opportunities for attending to anything but bodily, physical needs:

Thirty admissions a week for knee surgery and five to six hips...nobody fills in even box on the assessment form which includes...spiritual needs.

On the other hand, some nurses said that technological devices such as syringe drivers and incontinence care had improved so much in their careers that sometimes there was more time to sit and talk with patients, instead of running around doing tasks.

Lack of time and resources were however, not the only reasons for diminishing patient contact. Nurses had traditionally given patients listening time whilst engaging in what became known as 'basic cares', classically the bed-bath. However, most of the core nursing care of the person such as bed-baths and feeding was now carried out by Health Care Support Workers whilst registered nurses became more involved with paper-work and management issues to the detriment of 'hands-on' practical nursing. Jackie lamented the loss of this and said: *you felt you lost that caring, that hands on touching - we used to do back rounds bed-baths we don't now*. Similarly, Joan, considered time to be with the patient was very important. In describing how she perceived spiritual care in her nursing of people with dementias she said:

*I always thought I would be caring , even simple things like just knowing someone's uncomfortable [...] the physical body may be the only place of contact now, rubbing someone's hand ehm or the way you wash someone you know, it can be their last day unfortunately, but **how** you do that and the difference of doing it with kindness and intent and softness, in comparison to it being a task and both take time, [...] it takes time to*

say wash hair, but you can do it in such a manner where the response to the person as a relaxed individual.

Here Joan clearly described how close intimate contact with another's *physical body was the only place of contact now...how you do that makes the difference ...*

An extract of my continuing conversation with Jackie relates this shared experience:

Yes we used to do people's hair for them and they used to laugh at me when I was doing care of the elderly cos I spent hours on night duty making sure that all their clothes matched and you know people would say 'you know she's demented it doesn't matter what she looks like'; it matters to me cos she was somebody's mummy or granny and why should she have to wear clothes that don't match you know and its that kind of - they thought it was very funny-

Did they? the nurses?

Yes. 'Why are you wasting time?'- I'd go 'well she wouldn't suit that colour'.

[Shared laughter]

If you're doing it holistically I would say spirituality is intrinsic and in there unrepeatable from the rest of it

But you would say in your experience then it has been part of something you practised as nurse?

I shared Jackie's despondency about lack of time to care because it seemed that the lack of time and basic care of people that had been so central to nursing, and that people had identified as making them feel comfortable, cared for and even comforted, as my supervisor had said – being thoughtful enough to get mousse for her hair had raised her spirits, but would not be considered spiritual care. One may postulate, for a religious woman to say she valued her physical care, and the way nurses treated her with kindness and thoughtfulness, to be more important to her as a patient than nurses giving her spiritual care was illuminating. She valued this as being what she needed as a patient when distressed and sick. I wondered what else a nurse could reasonably be expected to give. Why, I continued to ponder, was a nurse expected to give spiritual care too?

The situation was similar with Jane, who was working as a midwife. When she had explained to me her interest in spirituality, especially in Eastern and other cultures, which I described in Chapter Three, she was unsure about it, saying: *I know it's*

about religious aspects and describing it as: *such a hard thing to define*, reflectively asking: *what exactly is spirituality?* Whilst she was uncertain as to how to describe or define it, she was even less clear when it came to relating it to nursing practice. Here I am linking with her specific lack of certainty about spiritual aspects in the context of nursing care, since the dominant discourse argues that nurses must give spiritual care otherwise care is incomplete. (Ross 1992) et al..

Jane told me how upset she had been about the poor standards of practical care of her friend:

You are supposed to be caring for the whole person and all their individual needs though I didn't find that when my friend [in named hospital] but, however, I wasn't impressed but mebbe I'm old fashioned about it I don't know.

Do you want to say any more about that or is it too distressing for you?

No I'm alright now but I just felt, I mean, I said to her 'are they alright in here?' but from what I saw the care wasn't all that hot. She was the best one in there - she died very quickly. It was the general nursing care. I mean for example there was like a - she had a real bad chest she was a bad asthmatic and there was like a bowl sitting there - oh this is nothing to do with spiritual care!

Um mebbe it is.

Mebbe it is - spit and old tissue in it and two auxiliaries came and made the bed next door but didn't lift it up so I lifted it and put it on the ...I though I'd better not start or I'll get into trouble. I just don't think the care is as good there too much emphasis on paperwork so...

I don't want to you know probe too much cos it might be too sore for you but, you know, you talked about the care not being good and the spit left on the...

Yeh I mean, do you think that's acceptable?

Well I don't, no, it's very distressing isn't it?

Well I mean suppose I was somebody that wasn't used to that it could make you sick couldn't it? I just think it's unacceptable.

This conversational extract with Jane is a good illustration of two things. One was the confusion in her mind between good nursing care and spiritual care and if good practical care of the whole person was spiritual care. *Maybe I'm labouring under a false...* she pondered, as she raised her uncertainty about what spiritual care by a nurse was. As this was the central focus of my study, I encouraged her to *tell me what you*

think about that and, when she did, it was related to practical care, *spit and old tissue* and *care not as good* as she had been trained to give. She continued:

I had another elderly friend in the same hospital, not the same ward, and his dinner was put on a table as far away as... [Points to a table several metres away] and he was in...his Us & Es⁶⁵ were up the shoot but nobody attempted to help him. I don't know whether that comes into spiritual care or I suppose it does in making somebody comfortable an... I don't know.

One of the causes of a raised Us and Es as Jane described is dehydration, hence her dismay that the patient's bedside locker on which fluids would be placed was out of reach of her elderly friend. She perceived this as a lack of care of the patient.

A second point was the continuing lack of clarity about how, from a nursing perspective, spiritual care could be separated from how the overall care needs of patient. They seemed interrelated in Jane's experience. Her experience had been the converse of Bradshaw's competent caring nurse and so had brought distress to her as a friend visiting her sick friends and diminished her confidence in the nursing care standards. As she exclaimed, with a measure of disgust: *it makes you sick doesn't it!* Furthermore, specifically, her experience made her question what was of real value to both her friends as patients and to nurses and nursing. However, she was unclear about the distinction between what she perceived as good core nursing and what was spiritual in that.

Nurses' own inner distress

Distress related to personal factors

Many of the nurses told me distressing stories of their own as nurses, and of the people for whom they cared as patients. These were often interwoven with their own personal stories of reflection on how they came to hold their current views about the spiritual.

Jennifer's close friend had died three weeks prior to our meeting and Jackie had had attended the funeral of a close family friend only two days before our meeting. As

⁶⁵ Urea and Electrolytes

she left she commented: *I am glad I haven't cried anyway*. This comment reassured me in some small way that our in-depth conversation was neither too distressing nor intrusive. However, it gave me quite a start as, despite my awareness of the potential sensitivity of my research topic, as well as my own experience, I had not sensed that this person was grieving. It was also interesting to reflect on the protective layer nurses build around them. Perhaps this was to protect themselves, or others, from their own distress. This theme recurred frequently throughout the interview conversations.

As part of the community of knowers in feminist standpoint methodology this was one of the many times when I felt we were all talking with each other about shared experiences and concerns. I found listening to several stories of distress had an impact on me as I identified with, and even imaginatively entered into, the world of the nurse as both professional and person, as well as that of the patient whose own world of pain and distress was being described. Quite often I felt drained by the end of an interview especially if, as happened some days, I did two or more interviews. An entry in my Reflective Diary said:

Immediately after this meeting [with E] I felt absolutely drained. So many important issues had come up and I didn't deal too well with all of them - lost my focus [spiritual care by nurses] at times. However as the interview is semi-structured and informal I was keen to let her ad lib and also to involve myself in the conversation so that it was less hierarchical with me as the Researcher and her as the researchee. But these are problems I hadn't thought about too well beforehand, except in the way I do when teaching the topic of spiritual care to nurses I suppose but research interviews in depth probing on a one to one for a whole hour is very different. (21/11/02)

Distress related to management

Quite as important as patients' views of spirituality are those of nurses about what they called their own spiritual needs. *I see I need to reinforce myself spiritually, I see it depleted at times when I am dealing with too many things at the one time* (Joan). This was closely interrelated with their feeling of being unable to care for the patients in the way they felt patients needed: *it's where I think it's work work work it grates*

me a little, (Joan) and that they themselves felt guilty when unable to meet the work load and standards: ...oh god I am horrendously out of order there but I do try.

The nurses' own distress was evident in the many stories told by participants in my study. Joan, who worked in mental health said, with feeling:

*...that's why we have the highest sick rate, we do, and I have seen myself at times ehm been unwell but not **physically** unwell, phoning in and just thinking I can't do this today I just can't.*

This inner distress was not only because suffering or inner distress of others was *in your face* on a daily basis, but *...because there has been some emotional upset in my own life*. Despite being at the point of burn-out and feeling their own inner pain and anguish, this was not noticed or acknowledged by anybody, *there was no exploration of yourself*. What Jo felt would be helpful would be *to talk over how you deal with people, teach people, and how you are, the person, the things that we face*. As a contrast, when she worked in the voluntary sector, still nursing people with mental health problems, she was:

...employed as a person [...] just had to be a human being, and that was so different in that I was allowed to say I am maybe not managing this, or I maybe need advice folk looking at you surprised in a sense - it was so very nice but you know I don't know if nursing is the only culture that is like that surprise mebbe social workers like that too.

She talked with so much depth of feeling about her experience of inhumane, indifferent, uncaring, management and expectations that were superhuman:

Something about being a nurse that you have to be super but if I worked in Safeway's I probably would have went in you know but there's an element of I just don't have it, I just don't, I've nothing.

Indeed the structure of nursing and patient care decisions added to the distress of the nurses, and patients. Jo expressed her experience of this forcefully: *as a profession we're so badly looked after, I think nurses are horrendously looked after*, though significantly she had found that when she worked in a voluntary organisation for care of people with mental health problems in the community (Penumbra):

I felt as an individual so much better looked after, I had regular supervisions, I actually on one occasion my work sent me for counselling over an incident that happened at work, very quickly, no messing around having to contact managers or anything like that and I felt very cared for ...and we had a system set up where we always in the office at the beginning and end of the day and we had good peer support and all that sort of stuff.

She had found quite the opposite, however, on return to work in the NHS where the way she was uncared for, and the material conditions in which she tried to care for people who were clinically depressed and even suicidal were significantly less pleasant than the classroom where we were sitting for our interview:

*Coming back to work in the NHS was like stepping back 20 years, I just thought 'God this is awful' [...] I remember thinking how **badly** looked after I felt the NHS [...] and it's so often worried me that is why as nursing staff after a time and after a fashion we have very little of our own reserves left to then, care for people, because nursing staff I have met have always come in with the best intentions, thankfully never met anybody who I really thought 'what are you doing?' they are very caring, very considerate, very loving people, but equally they are like the rest of the world, there are many times when you go to work and you think 'this is the last thing I want to do, don't want to be working today and unfortunately, as the years start to pass people start to tire, or what is the term used for it, [burnout] can they be expected to have loads or reserves to still do that, and that's when I do think washing hair becomes a task, a proper task - 'I've got Mrs Jones to get up next' and we use that and it's a shame ... that's where you get the niceness in your job - and it's a crap job at the end of the day cos you know you go into this pokey wee room you know.*

The sad thing was that like other nurses in my study, Joan had given up nursing after more than twenty years and was training to be a reflexologist at the time of our interview.

Each of these nurses communicated their skills and compassion as well as their knowledge of what the patients needed, yet they were prevented from meeting those needs by medical structures of treatment, or management. As a result, they left nursing. How would spiritual care-giving by nurses remedy such injustices in the work place? If spiritual care by a nurse is about caring, kindness and humanity, well

demonstrated by these nurses, in addition to their skill and experience, then greater care of them as individual people as well as professional practitioners would also serve the needs and interests of the patients. Joan had turned to Tai Chi

...to allow myself time out [...] I do have to care for myself when you get the idea of spirituality...that's how I see it I need to reinforce myself spiritually, when people care for me it does do something I don't know what it does but it does do something, it does.

Similarly, Susan, who had a degree in nursing and was also like Jackie a doctoral student, told me that she had left nursing practice because the Charge Nurse/ward manager did not like degree nurses or researchers. This whole “atmosphere” affected her life generally. Susan commented on the “*subtle power*” this manager had to belittle her attempts to care properly for dementia patients, as well as to make her dispirited by not giving her weekends off, as she was part-time, time she would have used to study for her doctorate in caring for dementia patients. Yet, as Joan had experienced, *in the voluntary sector it was so very different, and it's all the little things you know*. Joan found it difficult to talk about spirituality in concrete terms:

Can only think of myself as an example, when I have felt depleted and questioning of myself as a human being and what is this idea of 'me' and where am I going?' but in relation to assessing the spiritual needs of patients don't know how we put this on paper cos it's not tangible, it's not.

Distress related to doctors

There was a continuing interplay between the experiences the nurses had of the organisational structures of care and actual care which impinged on them as nurses and patient care. Adding to the accounts of Susan, Joan and Jackie above, Isla gave a fully descriptive account of the inter-relationship of what she called *the actual organisational structure* and poor personal care of patients in the acute surgical ward in which she worked:

Yeh yeh you've got the actual structure as well organisational structure er god it's just stress from the minute you go in to the minute you leave

again time, people, you're bombarded with it all the time - you are aware if patients got to go home you've got to organise transport, this and that, I know that's physical. Mentally as well I think that for myself - eh - you're in the atmosphere where a lot of people are ill and you do tend to think 'is the whole world ill!?' and it gets very stressful. A lot of our patients don't 'know' - they're coming in for surgery - that it might not be just that their appendix isn't too well. It might be - they've got cancer and that I think is stressful, stressful that you know but the patient still has to be informed - and - if they ask you - well that's the one question I dread, 'oh have I got cancer?' and you have to say 'well do you think you have?' and let them try and answer it for themselves and if not, you do have to say.

I quote this lengthy part of our conversation partly to show you, the reader, what it is really like for a nurse in an acute ward caring for patients, and partly to demonstrate how absorbed and even distressed Isla was by the whole experience. She was clearly sensitive to the way the patient(s) did not know but maybe feared 'the worst' and anticipated how bad news might and should have been conveyed to minimise the shock and distress. I sensed this in our interview conversation and shared her distress. I discussed with Isla if she thought care would be less stressful if the doctors were better educated in communication. She replied emphatically:

YES! [Laughs] certainly make our lives and the patients' a lot easier if they are more understanding mean the surgeons not just blurt it out and walk off!! Just a couple of the surgeons that you know you work with you say 'Thank you you've just said that in front of the patient! They're just totally stunned!' 'Let's try and pick up the pieces and help this person, cos at first they've got to come to terms with it.' I mean being told the information, trying to figure it out in their mind, to come to terms with it and sometimes patients are informed without their family being there.

When I heard this from Isla I was somewhat stunned since I thought medical education now included communication skills. A lot of the poor care identified so strongly by Isla was to do with professional roles, lack of communication between doctor and nurse as well as doctor and patient, which had an impact on the nurse and her role. I was not surprised when right at the end of the interview Isla said:

I handed in my notice yesterday...just came to a head. Just a lot happening on the ward and again no support and lack of staff.

She intended working independently as a Complementary Therapist after completing her current course, and would like to set up a service for staff, she said.

It is a concern that an experienced nurse such as Isla felt silenced by the power and authority of the surgeon to the extent that she felt anxious about my writing down what she had told me during the interview, as I wrote in Chapter Two. Isla's main unhappiness was with the way she described her extreme response to the surgeon's bad communication with the patient and with the nurses. Her anxiety was mainly concerned with talking honestly about the detrimental effect a surgeon's poor communication had on both patients and nurses. Her response to my writing out what she *said* with such vehemence was to ask to have it retracted from public view, something characteristic of people who are used to being subjugated and silenced. The voice can be heard, as in the interviews; but to have it heard or read by those in authority was a great worry for her. Here, as often in the accounts above, I felt as much part of the community of knowers as the people talking with me appeared to be: we had all experienced this silencing in the clinical area and in our academic lives too, where powerful 'others', usually men or people in 'public' masculine occupations such as medicine or religion, have silenced the voice of the carer, usually a woman, or a nurse.

The content of Isla's conversation was especially fruitful; it was what Geertz (1993:22) called 'thick description'. This means going deeper than the surface description to analyse the cultural and other aspects embedded in the story. Her thick description gave me accounts of the way poor medical communication with patients and nurses affects both nurses' caring and patient satisfaction. Holliday (2001) observes:

What makes the thick description of social phenomenon possible is not its exhaustiveness...but the way in which it scans the different facets of the ...culture within which it is found. (p.80)

The dominance of bio-medical treatment, even when treatment appeared futile, was a further source of distress. This was perceived as a spiritual problem though

this could be due to the proximity and eventual death of the patient whose care was described. Lilian told me of an African patient who was dying of HIV/AIDS and who wanted to return to her home to die in peace surrounded by her family, but the doctors persisted in trying different treatments, saying: *'Oh we'll just try this treatment or that treatment'* until the patient was too ill to move anywhere. She died in the acute ward, to the distress of the nurses caring for her, most of who attended her funeral in the absence of her family.

Discussion

These stories of dilemmas of care made me feel quite despondent. Isla had been a highly experienced, sensitive caring nurse, with a well-developed sense of humour, the very person I would have wished to have cared for me if I had been a patient. Now she was leaving nursing, along with Susan and Jackie. I wondered how getting these nurses to give spiritual care would help patients or nurses when the structures of bio-medical care, along with management understanding of the stress in the ward, militated against using existing the nursing skills? Their knowledge was subjugated and they were personally demoralised and dispirited. They felt they had to leave nursing completely since they felt unable to accommodate their own nursing care within that which the structures of care allowed. Yet they identified nurses giving spiritual care as the remedy to their own and patient's distresses.

These stories, like so many others, witness to the way women as nurses doing caring work are subservient to the masculinist management and scientific process which could be said to have objectified both nurses and patients, preventing them from living their full humanity.

I was upset by the accounts of these nurses since their careers as well as the care of patients had been badly affected. Caring for the carers was a recurring theme with almost all nurses to the extent that if a nurse did not mention it I said that others had and asked how this had been in her experience. These experienced, caring, nurses included their personal professional experiences in their discussions of what they considered spiritual aspects in nursing. A note in my Reflective Diary echoed my study experience:

Today I went to buy flowers. The florist was particularly helpful and when I told her the flowers were for a friend who had just passed her PhD viva. She asked me what the subject was. She told me she had been an Intensive Care Sister in paediatric cardiac surgery and after years in Glasgow and the Edinburgh had left due to the stress and impossibility of giving the care she wanted to give. I walked across the Meadows feeling very disconsolate. How many experienced nurses like her and Susan, Jackie and Ailsa were lost to patient care? And what would spiritual care as MP&F do to redress these losses? (28/10/04)

By using feminist standpoint methodology along with feminist informed theologies, I have been able to draw attention to experiences that otherwise might be silenced still further by spiritualising nursing care. This issue recurred throughout my study in several ways as I continued my quest to discover why nurses were asked to give spiritual care to patients. I return to discuss this in the next chapter of my thesis.

Summary

In their descriptions of nursing care, the nurses' experiences reflected the tension of views about spiritual care by nurses as either intrinsic to nursing itself (Bradshaw 1994) or, alternatively as something so vital to nursing care that without it, nurses failed to meet patient care needs (Ross 1992, 1997). Spiritual care was described as by the nurses in my study as nursing care, communication, companionship, being with and comforting, but which they felt was restricted due to organisational structures of care. Sometimes this was due to the nurses not having autonomy in patient care and treatment decisions which impacted on the quality of care they gave as well as their own satisfaction. There were difficulties in deciding how, or if, psycho-social care was different to spiritual care, unless the latter was specifically religious. Additionally, the stories of nursing care indicated the problems of power and powerless inherent in nursing and the possible relationship of this to why nurses should be expected to give spiritual care. In the following chapter I discuss this in relation to matters of care and spiritual care by nurses.

CHAPTER SIX

Spiritualising nursing care

In this chapter I offer a speculative discussion about why nurses are asked to give spiritual care and why the nurses felt this is what is needed. First I recap on each of the chapters in which I presented the interview materials. Directly or indirectly many of the nurses identified inner distress as spiritual so in this chapter I discuss this in a literary and theological context.

Spirit and spiritual care and its meaning for nurses

Difficult to say what 'it' is

Chapters Three, Four and Five demonstrated that, whilst nearly all the nurses in my study were not practising Christians, almost all had religious backgrounds and many of them described the spiritual as distinct in some way from the body. They believed in the existence of such a thing as 'spirit,' however defined. These included a religious spirit or soul and contemporary notions of spirit as 'self', 'essence', 'person', 'it' or something other than material bodily life. However, they did not think helping patients with meaning, purpose and fulfilment was their role in spiritual care. Indeed, they actively recoiled from the idea. Apart from specific cultural/religious needs, which may be grounded in ethical and cultural practices rather than spiritual ones, spiritual care by a nurse was seen in terms of caring about how a person feels regarding their illness, treatment, and impending loss of life; being with patients, especially in times of distress, and developing therapies such as therapeutic touch. The dominance of bio-medical models of care, as well as managerialism, meant that the opportunities for nurses to practise this more subjective nursing care were largely denied them. As one nurse in my study exclaimed indignantly: "*I feel robbed of the ability to practise.*"

From analysing the interviews with my study participants it seemed to me that there are several interrelated factors that need to be addressed for more intimate personal care to be given, regardless of whether it is called 'spiritual', 'intimate personal',

'holistic' or given any other label. One is that time needs to be allocated for this area of care. It takes time to listen and time to respond thoughtfully. As many of the nurses indicated, lack of time meant they were already unable to attend adequately to existing bodily care needs. Significantly, when nurses told me about what they and patients valued about hospital chaplains it was that they were perceived as having the time to talk with the patients, whereas nurses were continually occupied with treatments and other practical care-giving. Time to talk with those patients who need or wish to do so was recognised as essential to care across all specialities. It is very important that more planned support in these roles is given so that nurses do not have to struggle continually to cope with their own distress when caring for those in distress. This means they either leave nursing or they stay but effectively 'leave' in their hearts. The classic study by Menzies (1961) drew attention to the ways nurses cope with the distress of others by defending their own anxieties. Unfortunately, this means they may choose not to become involved with the patients' real needs for personal understanding of their fears, and so these may not be met. However, whilst such subjective or personal care should be included, it is important that it should not devalue practical, physical bodily nursing care. As Bradshaw (1994) argued, patients derive great comfort and peace of mind from competent nursing care.

Spiritual care by nurses as a gender issue

Secondly, as I discussed in Chapters One and Two and demonstrated from interviews in Chapters Three, Four and Five, the frequency with which nurses agreed that patients need spiritual care, allied to their enthusiasm for it, belied a deeper, underlying dissatisfaction with their experiences of nursing. Although they all spoke positively of nursing people as patients they as frequently spoke negatively and sometimes, indeed, vehemently, against the systems and structures of care within which nursing was practised. The twin aspects of the nurses' experiences can be said to be a gender issue. This can be argued from two views. Firstly, I have shown that nursing care is gendered as women's work and subordinated to masculinist values, such as medicine. Secondly it can be argued that the nurses in my study had unconsciously absorbed the dualistic hierarchy of values where spiritual care was

perceived as both superior to and necessary for bodily care. The nurses were mostly unable to separate spiritual care from nursing care except, in the main, when patients had specific cultural/religious needs. On the one hand the nurses described nursing care which was both valuable and valued yet, on the other, they described this care as subordinated to the demands and decisions of others such as doctors and managers.

As discussed in Chapter One, Lawler (1991) found nurses had no word(s) to describe their knowledge and experiences of caring for the intimate, physical needs of the body. Similarly, innermost care, as “emotional labour” (Smith 1992) or “intimacy” (Savage 1995) have been largely unarticulated in nursing. All of these authors discussed in Chapter One have linked this hidden or invisible caring to gender: it was argued that caring though invaluable to individuals and society was taken for granted, and considered ‘natural’ for women, both in the privacy of the domestic home and in public caring, as in nursing. This raises very important questions. Why did the nurses call intimate or personal care nursing care ‘spiritual’? I suggest this is because of the dominance of dualistic ways of thinking in Christianised societies, itself related to gender as I discussed in Chapters One and Two. This means that the material body and its various interrelated care needs are considered to be separate and even inferior to ‘higher’ care needs such as the spiritual/rational. Bodily needs are often ranked lower in value than the spiritual. However, whilst describing nursing care they considered to be spiritual, the essence of this care was competence, compassion and beneficence, given in a spirit of mutual humanity. Included were virtues of kindness, presence and being with patients in times of their distress, as well as technical abilities. Such virtues are already well-recognised characteristics of nursing (Bradshaw 1994, Campbell Gillett & Jones 2001, Tschudin 2003 et al).

Not only was the real work of nursing care hidden, unexpressed, and even inexpressible - typified by remarks such as *how do you describe the care you just GIVE to the patient?* (Joan) - it was further complicated because what was competent nursing care was now being called ‘spiritual’ care by my study participants. There was thus a mismatch between what experienced practising nurses considered spiritual care to be, and the type of spiritual care which the dominant authors are arguing is imperative for nurses to learn. I argue that one reason for this was that nurses as women and nursing as a feminine activity of caring are largely subjugated by

masculine medicine. The development of body/spirit binaries after patriarchal dualistic, Christian theology may perpetuate this demise of bodily care and, with it, nurses and nursing.

‘Spiritual’ care was perceived as overcoming, or rebalancing, the constraints of bio-medical treatments identified by participants in my study. This relates to Paley’s description of slave/master morality discussed in Chapter One and could be a factor in understanding why nurses may wish to welcome spiritual care by nurses. But would providing additional spiritual care be a help to nurses, nursing or patients? From the evidence of my study I suggest it is not, for nurses need to be empowered to articulate the needs of patients as well as their own needs for more humane relations. As Joan said:

How badly we are looked after...that is why nursing staff after a time and after a fashion have very little of our own reserves left to then care for people, because nursing staff I have met have always come in with the best intentions...you start to tire, or burnout can they be expected to have loads of reserves to still do that, and that’s when I do think washing the hair becomes a task, a proper task - I’ve got Mrs Jones to get up next...that’s where you get the niceness in your job - and it’s a crap job at the end of the day cos you know you are in a pokey wee room you know.

Conversely, however, as noted by Jantzen (1995), far from becoming assertive about their own and others’ needs, the mark of a truly spiritual person is to be meek, submissive and humble, by saying prayers and reading Holy Scriptures as authoritative in life. These in turn produce a meek, calm, submissive person:

It is clear that while a person may use these daily readings as a basis for daily meditation may well find herself calmed and encouraged, it is unlikely that they will provoke her to think hard about the social cause of her stress, let alone about the ways in which the structures of capitalist society produce the stresses she feels. (p.20)

In more contemporary mode, Wheen (2002) wrote that the vogue to seek solace in crystals was anti-rational and anti-Enlightenment where searches for ‘inner wisdom’ were:

...an expression of inner despair by people to improve their lives and [who] suspect that they are at the mercy of secretive impersonal forces [...] much the same function that Marx had attributed to religion – the heart of a heartless world, the opium of the people. Far better for the powerless to seek solace in crystals [...] and the myth of Abraham than in actually challenging [...] the social and economic systems. (p.193)

Accepting that spiritual care is what patients or nurses need could be said to be continuing to submit to powerful hegemonic religious authority, whether this is traditional or contemporary dualism. It is a way of dealing with material problems that ultimately are only likely to achieve yet more silence about real life concerns. Such concerns require material action rather than passive spiritualising of the issues. Given that this has been shown to have kept women subordinated to men in the home, the Church and society over the centuries of Christianities, as I argued in Chapters One and Two, nurses being asked to give spiritual care should be cause for concern, not capitulation. It may perpetuate the subordination of nurses and nursing to masculinist medicine and management by teaching them to accept, rather than challenge, this status quo. Submission will be complete if the masculinist trio is holy authority added to those of men as fathers and husbands on earth, as witnessed in history, as well as *her-story*.

What nurses and patients seemed to me to indicate they want and need is time and resources to give whole person care, which includes the needs for understanding of the inner self or person, as well as the bodily needs for nourishment and other activities of living or dying. But personal care is not what those who argue for spiritual care by nurses have in mind. They view spiritual care as a further care category, seeing it as transcendental to bodily needs. This has as its root the ideas of spirit or soul developed in Christianities. One reason for this, I suggest, is the decline in church membership and parallel growth in alternative approaches, which includes individualistic, consumerist spiritualities, often loosely called ‘New Age,’ or contemporary alternatives to traditional religious beliefs and practices: spirituality has become the new religion in a secular age (Heelas 2005). This has the effect of diminishing the numbers with church connections which impacts on the work of religious ministers, including hospital chaplains. Coutts (2001), for instance, wrote that the growth of interest in spirituality in the domain of health is “an exciting time

for chaplains” (p.1) which suggests that there is a correlation between the two factors I have just identified: namely, that if people do not have church affiliations before they are ill or dying, then those involved in giving them health care can encourage them to have spiritual care since, if this is included in everyday nursing assessments it will become part and parcel of nursing care and patients, when weak and vulnerable, are highly likely to agree to it. This raises questions about professional boundaries, competencies, trust and ethics. On the other hand, it could mean that chaplains are excited because spirituality has become such a buzz word that nurses will be alert to ‘inner’ needs of patients. In such a scenario, nurses might well involve chaplains in patient care when otherwise they may be more inclined not to see spiritual need in secular patients. But this begs the question of what spiritual care is in the first place. If ‘spirit’ is the breath, *ruah*, or electrical energy which enlivens the material body, as I argued in Chapter One, then it could be said that nurses by caring for the body in competent manner fulfil their professional requirement. If, however, there is an immortal substance soul or spirit, separable from the body and destined for life eternal in transcendental spiritual realms, however described, then it is questionable if such important and complex concerns could or should be within the competencies of a nurse.

Trust and ethical issues

If patients trust nurses to give them the care they believe is necessary for recovery or a peaceful death, they may feel it is normal to have spiritual care even if they would not normally believe in ‘spirit’ or ‘spiritual’ when strong and well. Moreover, the fact that nurses are being asked to provide additional spiritual care, without patients or practising nurses indicating a need for such a care category, raises questions of power. Although it is said that spiritual care would not be imposed, since patients have a choice whether to have spiritual care or not, it inevitably involves power dynamics between the weaker patient and the powerful health professional. As Tschudin (2003) observed, when people are patients they are in vulnerable situations and as such are easily influenced by outside factors such as family and friends. A nurse has a great deal of power over patients since he or she is trusted by patients. This is particularly so with weak and powerless patients, who may be elderly,

demented, confused or dying. I argue that adding spiritual care as a specific category of care to everyday nursing practice would make it normative. If a nurse appeared with a clip-chart to ask about a patient's spiritual needs, in much the same way as she does about bodily needs and functions, and asked if the patient found God a help (Stoll 1979), as every person has a need for Him (Fawcett & Noble 2004), then this could create a power dynamic where patients believed that spirituality was important for recovery or dying. Thus, conservative Judeo-Christian religious views of the world and people, divided into physical and spiritual, would be perpetuated in much the same way as religious practice was when the church had the power to enforce its dogma and teachings on societies. I discussed goddesses and witches as examples of this in Chapter One. Nurses have a duty to ensure that this does not happen and that they do not impose their own beliefs or non-beliefs, on vulnerable patients, whilst at the same time ensuring that those patients who wish spiritual or religious/cultural care do receive it (NMC 2004).

Suffering and grounding care by nurses

The third main aspect to my speculative discussion relates to the prevalence with which 'hidden' accounts of distress or suffering occurred in stories told by the nurses. This was paralleled by their own 'hidden' suffering, or inner distress, as nurses.

It was often difficult to separate out the experiences of the nurses from those of the patients for whom they cared, since these appeared to me to be intertwined. As with patient care needs, which the nurses identified as 'spiritual' but which were mostly subjective or psycho-social nursing care needs, so too the nurses described their own needs as 'spiritual'. However, many of the dispiriting nursing experiences stemmed from nurses' powerlessness in relation to medicine and management.

Suffering: meaning, medicine and management issues

Several nurses said that coping with their own feelings when faced with individuals who were ill and suffering had overwhelmed them to the extent that they could not face going to work. In addition, several spoke of unsympathetic or hostile

management, as well as less than pleasant working environments, that resulted in them wishing to leave nursing. Given that those affected are often the most sensitive nurses, who patients would wish to care for them, it seems to me that nebulous spiritual care will not meet nurses' needs for more humane relations with managers and work-place surroundings. Here, justice and emancipation issues come to the fore as I discussed in Chapter Two. The human heart of understanding and sympathy also needs to be developed and maintained. Nurses need support with facing suffering every day as many nurses in my study described.

Whilst the nurses recognised the importance of intimate personalised nursing care, particularly with dying people, they almost all identified distress to themselves and patients when they were prevented from giving the care they felt best qualified to do. *I felt robbed of the ability to practise*, said Jackie.

Others spoke of the difficulties they had in being sort of in the middle between doctors and care routines, and modern nursing is so machine, medicine and research-led (Moir). It would be nice to have time to be with people rather than just give out the basins for example (Dawn). As discussed in Chapter Five in particular, and elsewhere in relation to the interview materials, nurses wanted more time to care fully for patients as people, which would allow them to give both physical and psycho-social care. Often this included 'simply' being with a patient to share their distress; ensuring they were comforted and adequately supported when a bad diagnosis was given; respecting the rights of the patient to choose treatment or non-treatment and even taking on an advocacy role, as well as more obvious practical and techno-medical care. Usually there were several reasons given for not being able to give this kind of care, one of which was conflict with medical staff as discussed in Chapter Five.

McLean (1993) argued from her study of *Facing Death: Conversations With Cancer Patients* that patients often need understanding of their experience of the disease and its treatment (p.2) which is often not addressed by staff:

The diagnosis of leukaemia provides a great deal of information about the disease process and their treatment regimes; unfortunately, it discloses little about the person with the disease and it tells us nothing about the reality and meaning of the experience (p.1)

By 'being with' such patients, comforting them in their anxiety and distress, communicating painful diagnoses and treatments to them in the face of poor information and objectifying medical approaches, as well as in their specific nursing care competencies, nurses demonstrated that they know well enough what patients need. As one nurse said emphatically *I had the skills already* (Jackie). However, these skills are subordinated to the demands/approaches of medicine, to the detriment of patient care and nursing satisfaction.

Allied to the idea of nurses doing 'being with' others who are suffering is that of human benevolence towards others. This teaching is at the heart of all human cultures and religions. The Chinese character for benevolence depicts, in a single brush stroke, out-stretched arms (Mace 1996:18). In Judeo-Christianities there is the central teaching of loving your neighbour as yourself and of God suffering with us, though in nursing and life this is grounded, or embodied, in human flesh, both in sufferer and nurse. Many of the nurses described spiritual care as being human, warm and comforting in the face of cold technical treatment environments, and this is how they understood spiritual care etc. Was Bradshaw (1994) correct that competent nursing was sufficient to meet patient need; or was Waugh/Ross (1992/1994) right that nurses needed to give spiritual care in addition to bodily nursing care?

In relation to the question of suffering, there are two important issues which arise from my study. First is the communication of suffering and its importance to students of nursing. Second is the role that suffering can have for understanding and supporting those who themselves are suffering and even dying.

It may be that the initiatives to get nurses to give spiritual care will be a useful first step in opening up the debate about the need for both nurses and patients to have proper support in coping with suffering; however, it is extremely important that spiritual care does not become another check-list such as that developed by Stoll (1979). Ross (1992/1997) advocated use of the nursing process but this could impose an objectifying process onto a deeply personal and interpersonal encounter, as McLean (1993) argued from her study into how patients and nurses face death. To my mind, the nursing process of assessment, planning, implementation and evaluation of care means objectifying the innermost experiences of distress which nurses in my study described, and which they unwittingly called 'spiritual care.' Jo

Spence (1995), for example, felt passionately that “The objective view is not all there is to say” (p.215) about a person who is ill or dying. To communicate her inner experience of suffering from breast cancer and dying she used photographs. Instead of a list of signs and symptoms of dying a picture can make the invisible subjective experience more evident. This can help minimise the patient as ‘other,’ Is this kind of care spiritual or personal? Are they different? It may not matter to a patient or a nurse what label is given, as long as this care need is recognised. However, as I have been discussing already in this chapter, to call nursing care ‘spiritual’ care is potentially a disservice both to nursing and to professionals of spiritual care.

Aspects of these issues are addressed in teaching about loss, dying and grief; however the more existential elements are not. The latter inevitably involves elements of sharing the experiences whilst maintaining sufficient distance to prevent overwhelming distress on the part of either nurse or patient. Nursing practice continues to be a round of frenetic activity such as the traditional early morning rush to ‘do the basic cares’ which can become impersonal and in itself can be a ‘defence against anxiety’ (Menzies 1961). This can mean nobody /is able to stop and take stock of the human experiences of either being a sufferer or trying to be their carer. Nurses are thereby socialised into becoming the cool, detached professional, which may negate the wish to care for another human who is suffering that brought them into nursing in the first place (Melia 1981, Smith 1992).

Suffering seems to go by unnoticed, on the surface, as art teaches us. Breughel’s famous Fall of Icarus demonstrates how the world just goes on and great suffering is unnoticed. The birds sing, the sun shines and sets, ships sail and shepherds tend their sheep, the waves lap gently on the shore. In short life just goes on. In the midst of this peaceful pastoral scene a boy falls out of the sky, his legs disappearing into the sea. The poet W.H. Auden was inspired by the subtlety of Breughel’s painting when he wrote in his famous poem *Musée des Beaux Arts* about the nature of suffering and

Its human position; how it takes place
While someone else is eating or opening a window or just walking dully
along;
[...] how everything turns away
Quite leisurely from the disaster; the ploughman may

Have heard the splash, the forsaken cry
But for him it was not an important failure; the sun shone...
As it had on the white legs disappearing into the green
Water; and the expensive delicate ship that must have seen
Something amazing; a boy falling out of the sky,
Had somewhere to get to, and sailed calmly on.
(W.H.Auden, *Musée des Beaux Arts*, cited in Downie 1994 p.232)

The near banality of such unacknowledged suffering is reflected by the often frenetic activity that continues in nursing; the way nurses ignore the dying or death of another human being - the bed just disappears, as does the dead body. But what of the person? Were they the same, or was there a spirit, self or psyche that left the body? This is not spoken of; the teas are served and life just goes on, as indeed it must. However, people as patients and nurses need to give expression to all the various emotions and feelings involved in such situations, and to have space to acknowledge it all to themselves, too.

It was significant that so many people in my study remarked that our conversational interview was the only time in their careers that they had talked about innermost experiences of nursing/caring for people. The short-term as well as the cumulative effects of being ... *in the atmosphere where a lot of people are ill and you think 'is the whole world ill'?* (Jackie) takes its toll. There is no place or space to talk about these experiences, neither in educational programmes nor in practice. The nurses spoke frequently of the value of 'being' there with people who were suffering as patients however they spoke just as frequently of the lack of anyone being there for them. But will spiritual care facilitate this? It might, or it might not, dependent upon the humanity and sensitivities of the carers, as well as their managers. Perhaps it is true that there are some circumstances where silence is the better option. Walton (2002) suggested "...that material objects and physical gestures can embody what words may not..." (p.5). Importantly, she also draws attention to our limitations:

We will begin to learn that there are times when it is not right to make connections, supply meanings or resolutions for others. At points all we will be able to do is preserve the sanctity of their silence. (p.5)

Finding the answers to deep and complex questions about life, death and its possible meanings has occupied mankind, in particular, for millennia. Does feminine nurturing care give more insights? Feminist informed theologies suggest it does. I cannot answer definitively from my study. Why nurses should give spiritual care to patients remains a complex of professional and ethical questions. These are seen to be related to gender, power and emancipation matters of care.

Implications for further research

Further studies need to be done into the views of patients themselves, since indicators so far are that they do not expect nurses to give spiritual care in the way it is currently formulated in the dominant discourse. My study did not include the views of patients. Further studies that do this would be important to ascertain whether the current campaign to get nurses to give spiritual care to patients is motivated by patients' needs, or needs arising from both the declining church population and the spiritual beliefs of those involved in the campaign. The ethical implications of this also need further study.

A more in-depth philosophical analysis of the concept 'spirit' also needs to be undertaken. Although my study gave new insights into this from feminist perspectives, and these included hitherto excluded views, there nevertheless needs to be more research into whether spirit exists apart from breath or other life-giving material factors, all the more so as current nursing literature and research is heavily dominated by the patriarchal Judeo-Christian belief in a spirit as universal and transcendental to earthly and bodily life. Even within these traditions there are liberal liberationist, process and feminist approaches which are not at all evident so far in nursing literature and this therefore limits understanding by nurses. Related to this, interdisciplinary dialogue should be paramount to determine just what nurses should do in terms of professional religious/cultural representatives. It is clearly one thing for nurses to know about practices affecting bodily nursing; quite another to expect a nurse to be competent in giving spiritual care across the diverse spectrum of human beliefs and non-belief.

Further studies are needed to investigate whether suffering is spiritual and if so, whether it the role of a nurse to alleviate spiritual suffering as much as bodily suffering. Relevant here is also the issue of whether these two kinds of suffering can be distinguished from one another.

Investigating whose needs would be met by introducing spiritual care by nurses is an important area which was beyond the bounds of both my original study question as well as the material from my interviews with experienced nurses.

Although difficult to do because of the subjective nature of care and carers, relative costing should be carried out to determine whether one hour of 'spiritual' care by a nurse is as valuable as washing and styling hair; creaming drying skin; applying make-up; providing a healing environment with thoughtfully presented quality food and drink, flowers, plants, views of nature from sick-room windows; sitting with a lonely or anxious person; listening to life stories, fears and hopes people may have; having time and resources to bathe the body with gentle thoroughness; maintaining dignity and self-respect whilst attending to people who are incontinent; showing acceptance to the unloved and unlovely. I heard stories of each of these care practices by the nurses. They need to be better supported and recognised as of inestimable value to patients and their loved ones, as well as to nurses. To say that spiritual care matters more than these practices for nurses and patients are, to my mind, to subjugate more important matters of care to imposed patriarchal dualistic hierarchies. It is also to further subjugate the body and caring, whether given by women or men who are nurses.

Implications for policy makers, managers, doctors and nurses

The politics of spiritual care-giving by nurses need to be openly discussed, particularly by practising nurses and patients. As I have argued, the impetus for spiritual care by nurses is largely dominated by those who are Christian believers and who are not themselves practising nurses. This can be inferred from the lack of awareness on the part of my study participants that there was a drive to get nurses to give spiritual care to patients. This became evident in interviews, when, for instance, most nurses asked me for clarification about the whole topic of spiritual care by

nurses. Others were perplexed by or even aghast at by the whole idea of nurses giving spiritual care, even if they were themselves believers, or 'believers'. Therefore, more experienced and practising nurses need to be involved in discussions and decisions about nurses giving spiritual care. One such attempt to do this met with relative failure since the nurses in question said that, had they known the meeting was about nurses giving spiritual care they would not have attended.⁶⁶

A second recommendation is that management within the NHS, and especially of nurses, pays much more attention to the human and environmental side of nursing in providing professional support for nurses, particularly in areas of high stress, such as care of the dying, oncology and related areas, including mental health. Many nurses in my study identified the complete lack of any such care for them which was compounded by lack of understanding of their own needs as carers on the part of managers.

Additionally, there is a continuing need for better communication between medical and nursing staff, with equal opportunities for nursing care to have equal standing in patient care decisions. There needs to be greater recognition that subjective experiences are of equal validity to more objective medicine and management in care matters. However, whether these subjective experiences are spiritual or material remains an interesting question.

Summary

The findings of my study are that, apart from the very few patients for whom religious/cultural practices were relevant, the nurses were unclear about either spirit or spiritual care. The spiritual part of a person was variously described as 'essence', 'self', 'inner person', 'energy', 'core', 'something' and 'it'.

Gender is seen to be central in socio-cultural constructions of both caring and spiritualities. Consistent with the argument that patriarchal cultural norms and values are internalised on the part of the individuals or society, belief in hierarchical binaries of spirit/body persisted. Consequently, spiritual care by nurses was said to be

⁶⁶ Personal communication with Hospital Chaplain, Lothian Health NHS Trust (October 2003)

important by the nurses, even, at times, more so than bodily care. However, participants in my study were unable to distinguish spiritual care from bodily nursing care. In describing their experiences of spiritual care as nurses, they unwittingly identified it as good nursing care. Listening, comforting and being with patients, to enable or support them especially with experiences of illness and loss, were all predominant in their accounts of spiritual care. Such care, was, they felt, something nurses either just ‘gave’ to patients or ‘were’ with them. In other words, being kind, caring and competent in a spirit of mutual humanity was just part of the job of being a nurse. However, they considered this to be spiritual. There was thus a mismatch between what experienced practising nurses considered spiritual care to be, and the claims in the dominant discourse that it was imperative that nurses to learn additionally to give spiritual care. Although the nurses believed spiritual care to be important, what they described was nursing.

Furthermore, the nurses found it hard to express these experiences of care. Not only was the real work of nursing care ‘hidden’, or inexpressible, frequently, also, the nurses felt “robbed” of the ability to practice the art and science of nursing, because of the dominance of bio-medical and management structures.

Throughout my study I felt the value of using a feminist standpoint approach to knowledge creation. Firstly, enabling the experiences of everyday caring to be heard is valuable to nurses as it creates knowledge of their own work. Combined with a political emphasis this contributes to the argument that social, monetary and intellectual value be given to work previously considered as biologically ‘natural’ and socially gendered. As well as an emancipatory emphasis on knowledge creation, feminist standpoint creates knowledge of “sensuous activity” (Hartsock 1983: 292) which deepens consciousness of the material world and the body, to counter undue value given to the spirit/mind of dualistic world-views. A fourth area of usefulness of my selected methodology lies in its recognition of the heterogeneity of subjects together with what Harding (1986) termed the “multiple and contradictory commitments” (p. 66) of participants. Given the very wide range of materials that arose in interview conversations, this epistemic stance was invaluable since it challenged the dominant belief in a single unitary truth such as the claim that all humans had spiritual need for which nurses must care to create meaning purpose and

fulfilment. Thinking from several perspectives leads to questions which need to be taken to a wider community since this epistemic position recognises that the answers may well not be found in the situation in which the questions are asked. Here it again links to politics and emancipation for if the solutions require further investigation, this widens the remit and goes beyond the original scope of my study. This is therefore an important contribution to the debate about nurses giving spiritual care to patients.

In the dominant nursing discourse spiritual care is said to consist in helping the patient with meaning, purpose and fulfilment. This is said to be beyond physical life, in a transcendental realm, derived from implicit, or explicit, Christian beliefs. Although helping patients with some aspects of meaning, for nurses in my study this was mostly grounded in the practice of existing nursing care, rather than as existential or transcendental to bodily care. This included being there for and with patients in their times of vulnerability, being sensitive and responsive to patients' expressed or unspoken needs, giving comfort, and competent care. Beyond this, nurses in the study reacted strongly against nurses being asked to help with existential questions of meaning, purpose and fulfilment. The possibility of this, they felt, was precluded by the complexities of meanings in life, dying and death, as well as time and other resource constraints, which already compromised good nursing care standards. If spiritual care is about helping patients with existential meaning then this would mean manufacturing a care category which would destabilise other more important issues and concerns raised by the nurses. Moreover, it would have a malign influence on the real work of nursing as it would distort the real issues in the development of nursing as a profession. I argue that the development of spiritual care by nurses has important implications for both the recruitment and retention of people who wish to be nurses. Patients and nurses expect nursing to be about relief of mental, physical or social suffering, whereas spiritual care is associated with religions and the soul, however this may be described. This is quite different to the traditional work of a nurse to alleviate bodily suffering, which may include religious or cultural practices. But it is a very different thing for the nurse herself to be assessing and meeting spiritual need.

Wider dilemmas are posed by nurses giving spiritual care. The demise of church belonging and a rising tide of contemporary alternatives, a major concern. are the competencies of nurses to give spiritual care to patients across an ever-widening spectrum of beliefs and non-beliefs, from Paganism to Presbyterianism, and numerous shades in between,

The dominant discourse on spiritual care by nurses reflects conservative Judeo-Christian dualistic beliefs in a dualism of spirit/matter. Here God is believed to be the supreme Holy Spirit with all humans created in his image, and therefore with transcendental spiritual need. Emphasis on immortality in a spiritual realm, qua heaven, as more important than bodily earthly life was challenged by feminist informed theologies and spiritualities since it subordinated life, the body and women. Feminist informed theologies and spiritualities and post-structuralist feminism emphasise inclusiveness? rather than replacing masculine spiritualities with feminine. Although recognising there is no universal, essential woman, or man, nevertheless, women continue to be more involved with the body and its care, whilst men have been associated with abstract spirit. Bodily caring is less valued than traditional masculine pursuits.

Another related problem is the question of who will teach nurses to give competent spiritual care, should it be found essential for them to do so. Although I did not specifically ask too much on this topic, some of the nurses in my study raised this issue, believing from their own experience that it would be necessary to be taught by experts, such as chaplains. As some study participants commented: *...chaplains have had a lot of preparation for doing the job they do as well as a lot of experience.* Nurse lecturers do not usually have the requisite academic preparation, or the experience, for competent teaching of the complexities of spiritual care. Unfortunately, the likelihood of such a scenario in teaching spiritual care is infinitely more likely than in teaching biological aspects of care, yet each is multifaceted and important and requires in-depth study. Patients and nurses deserve well-qualified teachers.

Conclusion

Why then should nurses give spiritual care to patients? I suggest that it may be because a minority of people whose beliefs in a transcendental spiritual God compel them to believe all people have spiritual needs. Such people would have nurses become the unwitting Christian evangelists of the twenty-first century.

I began in by asking in my Introductory Chapter why nurses are asked to give spiritual care to patients. I have discussed differing views of spirit and the effects on the body women and nature, describing how dualisms of spirit/body are perpetuated in the experiences of nurses in twenty-first century Scotland. Doyle (1996) wrote that:

... we have commitment to the 'total good' [...] we have intrinsic aims such as the relief of physical or psychological suffering but attention to social and spiritual needs is an extrinsic aim. (p.viii)

Doyle (1996) said we should not interfere with people's spiritual needs, even supposing we, or they, knew what these were, since we may well do more harm than good. Those who want or need priests will seek them. Nurses, however, need to be able to practise the art and science of nursing. However whether that is a spiritual service of love to fellow humans, or a practice in need of loving attention from others, remains an interesting question. In conclusion, I think it is worth asking ourselves seriously, as did Doyle (1996):

...do we have as much right to involve ourselves with spiritual issues as we have with psychological and psycho-social suffering? (p. viii)

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APPENDICES

Interviewee Information

Name	Date of Interview	Age	Qualifications	Years / Nursing type of experience	Personal Religious / Spiritual Beliefs
Caitlyn	16/10/02	30	RN	7 – 8 / Care of Elderly	I am a religious person
Moir	21/10/02	56	RN, RNMH	35./General; Learning Disabilities	I'm not religious any more. I used to belong to C of E
Lilian	04/11/02	43	RN	22 / Adult /Palliative Care	I was brought up to go to Sunday school
Dorrie	28/1/002	38	General Nurse	17 / Chronic sick; disabled	My belief is that you should be a good citizen
Edie	15/11/02	55	RMN	34 / Care of Elderly; dementia	Yes there is a spirit ... ostensibly I am Cof S
Edna	18/11/02	39	RGN, RMN	21 / Psycho-geriatric/ dementia	[the spiritual side] is ... something
Isla	15/11/02	31	RN	11 / Acute surgery	No religion no
Jane	18/11/02	58	RM	35 / General Nursing Adult; Midwifery	I think there is some force somewhere
Joan	01/12/02	31	RMN	10 / Mental Health/Care of Elderly	I have no direct religious faith myself
Jackie	02/12/02	45	RN, RSCN	25 / General 14yrs; Paediatrics 10+	I was brought up a Methodist.(still practising)
Judy	13/12/02	52	RN	17 / Stroke Specialist Nurse	I'm a practising 'Christian'

Angela	06/02/03	40	NVQ BSc (CompTher)	3 / Oncology	I always believed in angels from being little
Lisa	14/03/03	35	RN	14 / Acute medicine	
Agnes	12/08/03	40	RN	20 / Acute surgical; District;	No I don't have a faith
Susan	16/09/03	33	BSc. (Nursing), RN	12 / Acute medicine/ Dementia	I was brought up in Cof S but not a church goer
Jane	15/11/03	28	Dip. N. RN	8 / Care of Elderly/ Oncology	None
Deirdre	17/11/03	58	RN	40 / Acute/Private	C/E C/S Practising
Jerry	19/11/03	25	RN	Care of Elderly; Acute neurosciences	None but interested

Nobody from ethnic minority who did not have Christian background

Most volunteers were older, more experienced nurses

Only two male volunteers (given female names for anonymity)

Letter of Introduction to Study Participants

Dear

I am writing to ask you if you would be willing to volunteer to meet with me to talk about aspects of nursing care. I am currently doing some research into nursing roles and would greatly value talking with you about your own experiences.

As you know, over the years, nursing care has developed and changed from task orientation, patient-centred care, nursing process /ADLS, named nurse and so on. There is a lot of contentious theoretical stuff about at the moment which says nurses should help patients find meaning in their experiences of illness and dying. To do this, it is recommended nurses need to add spiritual care to nursing care. My interest is whether this is really holistic care, or something else dressed up as holistic care. I am really interested in *your* views about whether you think nurses should help patients find meaning in their illness or dying. Also, whether you think this kind of care is really something nurses should be taught to practise.

My research is supervised by Professor Kath Melia of Edinburgh University's Department of Nursing Studies who has approved of my contacting you.

Initially I would like to talk with you, for up to one hour, at a time which is mutually convenient, preferably at Canaan Lane Campus when you are next here.

If you are willing to discuss this topic with me I would be very grateful if you could let me know by letter or phone or email. I enclose a SAE and my contact details are at the foot of this letter. If you would like to talk a bit more about it before agreeing to meet with me please feel free to phone me.

I will tape record conversations to help me remember what you said when I come to write it up. Pseudonyms, or other means of maintaining absolute confidentiality, are assured throughout the research process. There is no payment for your time, however I hope you will gain from being involved in a nursing research project. As is standard research practice, you will be asked to sign a consent form agreeing to participate. However you will still be free to withdraw from it at any time you wish.

I very much look forward to hearing from you. With best wishes and thank you for your time

Yours sincerely

Dorothy Grosvenor
Lecturer /
Pt PhD student

P 0131 536 5605/5600 E d.grosvenor@napier.ac.uk

Topic Questions used in Interviews

Introduction

Thank you very much for coming along. As you will see in the information I posted to you I am interested in talking with you about your experiences of holistic nursing care. My investigation is into why nurses are being asked to give spiritual care to patients.

- 1. Is the idea of nurses giving spiritual care new to you?**
- 2. What or how would you describe ‘spiritual care’?**
- 3. Spiritual care is defined in most of the literature and research as “Helping a person to find meaning purpose and fulfilment.” How do you see yourself as a nurse helping a patient to find MP&F?**
- 4. Do you think you already give spiritual care as part of your holistic nursing care? Or not? Can you go on...?**
- 5. How do you think spiritual care by a nurse would be different from holistic nursing care?**
- 6. Can you think of any patients you have nursed where your nursing care could have helped them find meaning purpose and fulfilment?**
- 7. Do you think if you had specific training/or education for helping patients find meaning purpose and fulfilment, it would be a role you could see yourself in as a nurse?**
- 8. In your experience do you think patients themselves expect you to give spiritual care?**
- 9. What are your personal views about what the spiritual part of a person is?**
- 10. Do you have any other views or comments on this topic which we have not talked about so far?**

Thank you very much again for taking the time to come and talk with me today. I really appreciate you giving up an hour of your time.

Consent sheet agreeing to be interviewed as part of doctoral study by Dorothy Grosvenor, Department of Nursing Studies, University of Edinburgh

Principal Supervisor: Professor Kath Melia, Department of Nursing Studies

Second supervisor: Doctor Marcella Althaus-Reid, Faculty of Divinity, New College

I.....of.....
hereby consent to be a participant in a human research study, to be undertaken by Dorothy Grosvenor, entitled:

An exploratory study into why nurses are taught to practise specific spiritual care additional to holistic bodily nursing care

The research and my involvement in it has been explained to me in writing and verbally. I understand that I will be encouraged to discuss issues regarding teaching nurses to practice specific spiritual care of patients.

I understand that:

- after I sign this consent form I will be interviewed by Dorothy Grosvenor for approximately one hour. There may be a second interview agreed to with me.
- a tape-recording will be made of the interview

I will receive a copy of the tape recorded transcript involving my conversation

I can clarify any misconceptions I find about what I said or meant to say in the researcher's document, by letter or e-mail.

I acknowledge that:

I am over 18 years of age and that the aims and anticipated benefits and possible hazards of the research have been explained to me.

I voluntarily and freely give my consent to my participation in the research.

I understand that the aggregated results of the study will only be used for research purposes and may be reported in professional and scientific Journals and/or conferences.

Individual results will not be released to any person except on my authorisation.

- I am free to withdraw my consent to participate at any time, in which event my participation in the research will cease immediately and any information obtained from me to that point will be destroyed, if requested by me.

- I understand that my identity and the identity of any persons, places and events about which I speak will be protected by the use of pseudonyms.

Signed:

Participant.....date

Witness..... date